STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING & REHABILITATION	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced onsite recertification survey and complaint investigation was conducted 11/18/2024 through 11/22/2024. Additional information was obtained offsite 11/23/2024 through 11/27/2024. Therefore, the exit date was changed to 11/27/2024. The facility was found in compliance with the requirement at CFR 483.73, Emergency Preparedness. Event ID # 5UMU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 11/18/24 through 11/22/24. Additional information was obtained offsite 11/23/2024 through 11/27/2024. Therefore, the exit date was changed to 11/27/2024. Event ID# 5UMU11. The following intakes were investigated NC00224553, NC00224528, NC00224313, and NC00223653. 3 of the 6 complaint allegations resulted in deficiency. Intakes NC00224313 and NC00224553 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J); the IJ began 9/14/2024 and was removed 11/23/2024. CFR 483.12 at tag F600 at a scope and severity (J); the IJ began 9/14/2024 and was removed 11/23/2024. CFR 483.25 at tag F684 at a scope and severity (J); the IJ began 9/14/2024 and was removed 11/23/2024.	F 000		

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

Electronically Signed | 12/20/2024

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F 000	Continued From page 1 CFR 483.25 at tag F689 at a scope and severity (J); the IJ began 11/15/2024 and was removed 11/19/2024. The tags F600, F684, and F689 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		12/18/24

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F 578	Continued From page 2 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident and Resident Representative (RR) interviews, the facility failed to ensure advanced directive information was correct throughout the medical record for 1 of 5 residents (Resident #65) reviewed for advanced directives. Findings included: Resident #65 was admitted to the facility on 10/17/23. A review of Resident #65's medical chart located at the nurse's station revealed a signed Medical Orders for Scope of Treatment (MOST) form dated 10/18/23 signed by the RR and the Nurse Practitioner that read Attempt Resuscitation (cardiopulmonary resuscitation). A review of the care plan meeting note written by the Social Service Director dated 8/14/24 revealed Resident #65 and her RR attended the meeting and Resident #65 desired for her code status to be changed to Do Not Resuscitate (DNR).	F 578	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F578 1)Resident #65's physician orders and electronic medical record was updated on 11/22/2024 to reflect accurate code status. 2)Residents with Advanced Directives have the potential to be affected. the Director of Nursing/Designee completed an audit of current residents to ensure each resident had an advanced directive completed, orders and care plans. Areas of concern were.	

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F 578	Continued From page 3 A review of the electronic medical record (EMR) indicated Resident #65 had an active physician order dated 8/20/24 that read Full Code. A review of the quarterly Minimum Data Set (MDS) dated 11/07/24 revealed Resident #65 was moderately cognitively impaired. A review of the care plan dated 11/12/24 indicated Resident #65's code status was DNR. An interview with Unit Manager #1 on 11/20/24 at 3:07 PM revealed the Social Service Director was responsible for reviewing code status with the residents and/or the RR and updating the MOST form if there was a change. She indicated the Social Service Director then notified the nurse manager so they could obtain the physician's order and update the EMR. Unit Manager #1 stated she was not aware that Resident #65 had a change in her code status. An interview conducted with the Social Service Director on 11/20/24 at 3:20 PM indicated she reviewed code status with the resident and/or RR quarterly with the care plan. She stated if the resident and/or RR desired a change she updated the MOST form and care plan and then notified the nurse manager to obtain the physician order and update the EMR. She indicated she did not recall Resident #65 changing her code status to DNR during the care plan meeting on 8/14/24. The Social Service Director revealed she was unsure why Resident #65's care plan reflected the change to DNR, but the MOST form, physician order and EMR had not been updated. An interview with Nurse #2 on 11/21/24 at 9:02	F 578	immediately corrected. This audit was completed on 12/12/2024. 3)The Director of Nursing re-educated the Social Service Director and the Unit Manager on completing the MOST Form and updating the electronic medical record. This education was completed on 12/13/2024. The Director of Nursing/Designee re-educated Licensed Nurses on completing the MOST forms, and updating the electronic medical record. This education was completed on 12/17/2027. This education will be added to the facility orientation program for Director of Nursing, Assistant Director of Nursing, Social Service, Unit Manager new hires, and Licensed Nurses, including agency staff for these positions. 4)The Director of Nursing and/or designee will randomly audit 5 current residents advanced directives and all new admissions and re-admissions weekly for 12 weeks to validate the electronic medical record has been updated to reflect the residents current code status. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI	

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F 578	Continued From page 4 AM revealed to determine a resident's code status she looked at the EMR or the resident's MOST form located in a chart at the nurse's station. Nurse #2 indicated Resident #65's code status was Full Code. An interview conducted with Resident #65 and her RR on 11/21/24 at 3:45 PM indicated Resident #65 desired to have a DNR and did not want to be resuscitated. The RR stated they have discussed Resident #65's code status with the Social Service Director and the facility was aware of her wishes. An interview was conducted with the Director of Nursing (DON) on 11/22/24 at 10:25 AM. She stated the Social Service Director reviewed code status with the resident and/or RR quarterly and if there was a change she updated the MOST form and the care plan. She indicated the Social Service Director also notified the nurse manager of the change so they could obtain the physician's order and update the resident's code status in the EMR. The DON revealed when a resident changed their code status the medical record should be updated and the code status should be correct throughout the resident's record.	F 578	committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		11/29/24

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F 580	Continued From page 5	F 580		

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations

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F 580	Continued From page 6 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Resident, Nurse Practitioner (NP) #2, NP #3 and Medical Director (MD), the facility failed to immediately consult with NP #3, the on-call medical provider, when Resident #49 who had a pre-existing traumatic brain injury lost consciousness and was slumped in his chair after being hit on the back of his head by Resident #79, his roommate. On 09/14/24 at 9:05 AM Nurse #3 heard a loud hit or thud coming from across the unit. She noted Resident #49 was in his wheelchair rolling out from his room and witnessed Resident #79 swing his arm with a fist and hit Resident #49 on the back of the head. NP #3 was notified after the incident occurred about an altercation between Resident #49 and Resident #79 but was not consulted about the blow to Resident #49's head, the slumping in the chair and the loss of consciousness for a few seconds. Resident #49 had a change of condition after the altercation occurred. He slid out of his wheelchair. His level of assistance needed for transfer and bed mobility changed and he was confused. Later in the day and as his condition continued to decline, staff assessed Resident #49 with altered mental status (AMS) and he was sent to the hospital for evaluation due to a concern for a concussion after a fall. The deficient practice affected 1 of 3 residents reviewed for physician notification (Residents #49). Immediate jeopardy began on Saturday, 09/14/24, when the facility failed to immediately consult with NP #3 about Resident #49 who had a pre-existing traumatic brain injury and had a significant change in condition following a blow to	F 580	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance F580 1)On 9/14/2024 Nurse #1 notified the on-call Nurse Practitioner (NP) at approximately 10:00 AM to report the altercation with the roommate and change in level of care needs, as more assistance was needed with transfers as it took several people to get him into the bed. The Nurse Practitioner arrived at the facility at approximately 3:20 PM and examined the resident related to mental status changes after an altercation with his roommate. The Nurse Practitioner arrived at the same time as EMS who had been called by the nurses and upon examination by the NP, the NP determined that the resident did not need to go out to the hospital, so EMS was turned away.	

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F 580	Continued From page 7	F 580		

the head with a brief loss of consciousness. The immediate jeopardy was removed on 11/23/24 when the facility implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective.

The findings included:

Resident #49 was admitted to the facility on 10/18/2023 with a diagnosis of traumatic brain injury (TBI).

A review of Resident #49's quarterly Minimum Data Set assessment dated 07/26/24 revealed he was cognitively intact. Resident #49 was coded as independent for eating and putting on/ taking off footwear. He required set up or clean up assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene. Resident #49 required supervision assistance for chair to bed transfers, toileting transfers, tub/shower transfers and lying to sitting on the side of the bed. The resident was noted to be independent for rolling left and right while in bed. Resident #49 was continent of bowel and bladder during the assessment period and was documented to have no behaviors.

A nursing note written by Nurse #3 dated 09/14/24 at 10:11 AM revealed she heard hitting noises and turned around to observe Resident #79 hit Resident #49 get hit in the head. The note revealed the residents were separated and assessed for injuries. Resident #49's vital signs

The on-call Nurse Practitioner was notified at
approximately 6:15 PM after Resident #49 was noted to be lying on the floor after sliding out of his wheelchair with Altered Mental Status (AMS). Resident was sent to
the hospital for further evaluation due to a concern for a concussion from the hit to the
back of Resident□s head on 09/14/24.
Hospital records indicate no acute trauma or concussion diagnosed related to the event.
Resident #49 returned to the emergency room
on 09/17/24 and was admitted for further neurological workup to include a Magnetic
Resonance Imaging (MRI). MRI showed redemonstration of severe infratentorial and infratentorial white matter signal abnormality mildly worsened since prior MRI of 2020. It showed decreased edema signal within the brainstem, moderate ventriculomegaly, secondary to white matter volume loss. There was no acute infarction. No significant vascular disease. MRI of the Cervical Spine showed severe C4-5 left foraminal stenosis.

On 11/21/24 and 11/22/24, a nursing assessment
was completed by the Licensed Nurses to verify
all residents were currently stable and were not experiencing a change in condition

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F 580	Continued From page 8 were the following: blood pressure 138/66; pulse 72; temperature 97.9; respirations 20; and oxygen saturation level 96% on room air. The Resident was noted with no signs of acute distress at the time of the incident and no complaints of pain. Redness was noted to the back of the Resident's neck. The Resident's Responsible Party, Director of Nursing and on call Nurse Practitioner (NP #3) were notified about the abuse and the Resident's status. On 11/19/24 at 11:38 AM an interview was conducted with Nurse #3. Nurse #3 stated on 09/14/24 around 9:00 AM she heard a loud hit or thud coming from across the unit. She then saw Resident #49 rolling out from his room in his wheelchair and witnessed, Resident #79 swinging his arm with a fist and hit Resident #49 in the back of the head making a second thud sound as his fist hit the back of Resident #49's head. Resident #49 immediately slumped over in his wheelchair as a result of the incident. Nurse #3 stated Resident #49 regained consciousness within a couple of seconds after she got to him to assess his condition. She stated she saw redness at the back of Resident #49's head and neck area. When Resident #49 "came to" he asked to go outside to smoke so NA #2 took him to the smoking area. Nurse #3 indicated she had obtained initial vital signs on Resident #49 which were within normal range, assessed him. Nurse #3 stated she did not recall reporting the loss of consciousness and slumping in the chair to Unit Manager #1. Nurse #3 explained Resident #49 was moved from his hall around 10:00 AM. Nurse #3 no longer was his nurse and did not see him again that day. The interview revealed Nurse #3 had initiated an action rounding log which documented where Resident #49 was in the	F 580	requiring notification to the physician for further orders. The nursing assessment results are noted in the residents electronic health record. The DON reviewed the results of the Licensed Nurse assessments and the 24-hour report to ensure there were no residents experiencing a change in condition requiring notification to the physician for further orders. Additionally, the DON reviewed the 24-hour report to ensure no other incidents requiring notification to the provider for which the Medical Provider had not been notified. No adverse outcomes were identified in this audit. Nurse #1 was re-educated on notification of medical provider per the policy and procedure for a resident with a change in condition on 11/22/24 based on the urgency of the situation to include but not be limited to falls, resident to resident altercations, injuries, unstable vital signs, head trauma and indwelling catheter with recurrent symptomatic urinary tract infections, or recurrent pneumonia, changes in skin color or condition. All licensed nurses, agency/contract staff, and all newly hired licensed nursing employees along with Certified Nurse Aides were re-educated on proper notifications to the Medical	

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F 580	Continued From page 9 facility every 15 minutes. Nurse #3 stated Nurse #4 took over Resident #49's care when he moved to his new room around 10:00 AM. On 11/21/24 at 12:32 PM an interview was conducted with Scheduler #1. She stated she was working as the Manager on Duty on 09/14/24. Scheduler #1 stated her office door was open and she overheard a nurse screaming for help. When she went out into the hall, she saw Nurse #3 in the hall and went to her. She noticed Resident #49 sitting in his wheelchair slumped over around 9:00 AM. Nurse #3 explained to her that he had just been hit in the back of the head by his roommate. After separating the residents, she stated she notified Unit Manager #1 via the facility paging system and Nurse #3 called the Director of Nursing. Scheduler #1 stated Resident #49 was taken to the smoking area because he stated he wanted to go smoke however she stated she did not see him smoking. She stated Resident #49 immediately seemed spaced out and not to be thinking clearly when he went to the smoking area around 9:30 AM. When he initially woke up after being hit and "came to," his abilities were not the same, he was using his hands but nothing else like he had before. The interview revealed Resident #49 started trying to go in the wrong direction and had to be redirected by staff, they took him to his new room, and it took Scheduler #1, NA #2 and Nurse #3 to all assist him into the bed. Scheduler #1 stated she left the building at 3:00 PM. She stated they were so concerned with Resident #49's condition they had placed a fall mat under his bed because they felt like he may have a fall from the bed due to his state of immobility. Scheduler #1 stated she did not voice her concerns to anyone because she thought Nurse #3 and Nurse #4 were	F 580	Provider or to the On Call Provider after hours and on weekends when a resident has a change in condition or incident, immediately after the incident or immediately at the time when a change in condition occurs. The On Call After Hours provider numbers are posted at each nurse□s station. This re-education was completed by the Director of Nursing/Nurse Manager on 11/22/2024. Nursing staff who were not educated by 11/22/2024 were re-educated prior to the start of their next scheduled shift, either in person or by telephone. This education was completed on 11/22/2024 This education will be added to the facility orientation program, to include Licensed Nurses, Certified Nurse Aides, including agency staff. The Director of Nursing/Designee will audit the 24-hour, including SBAR assessments 5 times a week for 12 weeks to ensure changes in condition are reported to the Physician or Nurse Practitioner. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility□s monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations	

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communicating the Resident's changes to the Medical Provider.

On 11/19/24 at 12:52 PM an interview was conducted with Nurse Aide (NA) #2. NA #2 stated she was responsible for Resident #49 on 09/14/24 during first shift (7:00 AM to 3:00 PM). She stated she did not witness the incident but was notified of what had happened by Nurse #3. NA #2 recalled she was told by Nurse #3 to take the resident outside to smoke and to move Resident #49's belongings out of his room into a new room on another unit. NA #2 indicated she moved Resident #49's belongings and assisted him from the smoking area to his new room around 10:00 AM and assisted him into the bed which was different from that morning. Earlier in morning, he was able to transfer himself. The interview revealed when she went to the smoking area to get Resident #49, he did not have a cigarette and was just sitting outside. NA #2 stated she immediately noticed a difference in the way Resident #49 was responding and moving around 9:30 AM when she took him to the smoking area. He was unable to self-propel his wheelchair. NA #2 stated Resident #49 could not assist her at all for bed mobility and had to remain in bed for the rest of her shift. NA #2 stated she did not recall Resident #49 eating lunch on 09/14/24. Resident #49 had gone from being able to transfer himself that morning to being unable to roll from left to right in the bed following the incident occurring around 10:00 AM and providing incontinent care while the resident was in the bed. NA #2 also noted Resident #49 seemed slow to respond when spoken to immediately following the altercation. NA #2 stated she had discussed Resident #49's change of condition with both Nurse #3 and Nurse #4 as

and
changes as indicated based upon the findings of the audits.

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soon as she assisted Resident #49 into his bed that morning. NA #2 stated she was not given instructions to obtain vital signs on Resident #49 during first shift and gave report to NA #1 at 3:00 PM.

On 11/19/24 at 2:00 PM an interview was conducted with NA #1. During the interview she stated she came on shift at 3:00 PM and received a report from NA #2. She and Unit Manager #1 assisted Resident #49 to his wheelchair because his legs were dangling off of the bed. NA #1 noted Resident #49 to be disoriented, leaning back in his wheelchair, sliding out of his wheelchair and overall, not looking like he typically did sitting up, self-propelling himself in a regular wheelchair in the hallway. Resident #49 was incontinent of urine and staff were changing his brief while he was in bed. NA #1 remembered having assisted him back up in his wheelchair during that evening and he eventually had a fall around 6:30 to 7:00 PM after sliding completely out of his wheelchair into the floor in the hallway. The interview revealed Resident #49 was sent to the hospital for an evaluation. NA #1 stated she did not recall obtaining vital signs for Resident #49 nor was she asked about his condition. The interview revealed she had notified Nurse #4 during her shift around 4:00 PM that Resident #49 seemed different from his baseline state.

A late entry incident report dated 09/14/24 at 11:02 PM written by Nurse #4 revealed Resident #49 had experienced a fall and was found in the hallway sitting on his bottom around 6:30 PM. Resident #49 stated he had slid off his wheelchair. No injuries were observed however the resident was sent to the hospital due to recent change in cognition.

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On 11/19/24 at 2:49 PM an interview was conducted with Nurse #4. She stated she was in the building on 09/14/24 during the first shift (7:00 AM to 3:00 PM) and second shift (3:00 PM to 11:00 PM). The interview revealed Resident #49 was moved to her hall following an altercation with his roommate where he was hit in the back of the head. She stated she assumed Resident #49's care for second shift at 3:00 PM. She stated she did not recall the exact time the resident was moved to her unit. The interview revealed Resident #49 was noted to be in bed, which was not typical for him. Nurse #4 stated she was not very familiar with the resident however she did know he was typically up during the day. She stated the nurse aides were telling her he was experiencing a significant change of condition from his normal baseline. She stated she did not contact the on-call provider. The interview revealed Resident #49 was gotten up to his wheelchair for the supper meal and he kept sliding out of the wheelchair. Nurse #4 had to obtain other staff members to assist her to pull him up in his chair. She stated around 6:30 PM Resident #49 was noted to fall out of his wheelchair into the floor in the hallway. The interview revealed he was immediately sent to the hospital for an evaluation based on the nurse aides telling her of the resident's drastic change of condition. Nurse #4 stated she had known Resident #49 was independent in his wheelchair, however when he left to go to the hospital, he was dependent upon staff for all transfers.

On 11/21/24 at 9:06 AM an interview was conducted with Unit Manager (UM) #1. During the interview UM #1 stated on 09/14/24 around 9:00 AM she was paged on the overhead call system

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to come to Resident #49's room around 9:00 AM. Upon arrival Nurse #3 told her Resident #49 had been hit on the back of his head by his roommate. UM #1 stated she looked at the Resident and he was able to respond to her. UM #1 had NA #2 remove Resident #49 from the room and contacted the Director of Nursing (DON) who stated she (UM #1) needed to notify the resident's family and the provider on call. (UM #1) stated the provider on call (NP#3) asked her how the resident was doing, and UM #1 stated it was her first time laying eyes on him, and he seemed okay so she told the provider he seemed fine with no injuries. NP #3 instructed the facility to notify her of any change of condition. UM #1 stated NA #2 immediately moved Resident #49 to another room around 10:00 AM. Unit Manager #1 stated as she was rounding later in the day around 2:30 PM and saw Resident #49's call light on, she stated he was trying to transfer himself from the wheelchair to the toilet which the NA said he was normally able to do. UM #1 stated she had to get two other staff members to assist due to his observed weakness. She stated Resident #49 was so weak she asked the Resident to hold off on all transfers for the rest of the day because he was a full assist. She contacted NP #2 who told her she would be in the building to round shortly. UM #1 stated the DON told her to activate Emergency Medical Services (EMS) because she did not feel comfortable with his condition. EMS arrived at the same time as NP #2 came onsite around 3:00 PM. NP #2 completed an assessment of Resident #49 and stated to her (UM #1) to turn EMS away because the resident had no reason to go out for an evaluation. She stated shortly after she had them turn EMS away, Resident #49 slid out of his wheelchair onto his bottom. Unit Manager #1

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called NP#2 and stated Resident #49 was going to be sent to the hospital for an evaluation. UM #1 stated the staff had moved Resident #49 to his wheelchair because his legs kept dangling off of the bed and she was afraid he was going to fall.

On 11/22/24 at 9:38 AM an interview was conducted with Nurse Practitioner #3. During the interview she stated she was the on-call Nurse Practitioner assigned to the facility on 09/14/24. NP #3 stated she did recall being notified of an altercation with Resident #49 around 9:00 AM but did not recall specific details of the incident or who notified her. NP #3 stated if she was notified a resident was struck in the head she would recommend sending the resident to the hospital for an evaluation. She stated she was not contacted by the facility for Resident #49 anymore that day because they had an in-house NP (NP #2) who was rounding on the residents. The interview revealed she did not have any notes from the day as to what orders she gave the facility.

An SBAR (Situation, Background, Assessment and Recommendation) Summary dated 09/14/24 at 3:35 PM written by Unit Manager #1 revealed Resident #49 had experienced a change of condition after a physical altercation with another resident. The chief complaint was listed as Resident #49 had become increasingly weak on the left side after a physical altercation at the hands of another resident. The on- call provider was notified of the resident's condition and instructions were placed to activate Emergency Medical Services (EMS) for an evaluation at the Emergency Department.

A SBAR (Situation, Background, Assessment and

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Recommendation) Summary dated 09/14/24 at 3:35 PM written by Unit Manager #1 revealed Resident #49 had experienced a change of condition after a physical altercation with another resident. The chief complaint was listed as Resident #49 had become increasingly weak on the left side after a physical altercation at the hands of another resident. The on- call provider was notified of the residents' condition and instructions were placed to activate Emergency Medical Services (EMS) for an evaluation at the Emergency Department.

On 11/22/24 at 9:14 AM an interview was conducted with Nurse Practitioner #2. She stated she was an in-house provider that rounds in the facility on the weekends. She stated she remembered evaluating Resident #49 while he was sitting in a chair and did not know what had happened that morning with an altercation. NP#2 stated she only recalled sending the resident out to the hospital following a fall and did not recall telling anyone to stop EMS from coming at 3:00 PM. She stated when the resident became unstable and fell, she sent him out.

EMS records dated 09/14/24 revealed they were dispatched to the facility with a chief complaint of increased weakness and a fall after an assault earlier in the morning. The resident had a history of TBI and wanted to be evaluated. Resident #49 stated he was hit in the head by his roommate earlier in the morning around 9:00 AM. He stated the roommate used his fist to hit him in the head and denied loss of consciousness. Staff, however, said the resident lost consciousness. The resident was cleared initially by his facility physician (NP #2) to stay at the facility and not be transported to the hospital. Around 6:30 PM

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Resident #49 was sitting in his wheelchair, when he tried to reposition himself. He had increased weakness that caused him to slide down the chair onto the floor. Resident #49 was noted to be on the floor until a medic arrived.

Hospital records dated 09/14/24 revealed Resident #49 was evaluated on this date after sliding out of his wheelchair around 6:30 PM. Per the Medic the resident was also punched in the head by his roommate earlier in the morning around 9:30 AM but cleared by the facility. A computed tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility with strict precautions to return with any new or worsening symptoms.

Hospital records dated 09/17/24 revealed Resident #49 presented to the hospital for evaluation of acute chronic left-sided weakness. The resident was reported to be punched in the head by a roommate three days prior. He was originally evaluated in the Emergency Department on 09/14/24 and cleared for discharge. He presented back to the hospital complaining of lightheadedness and felt that his left side was weaker than his baseline from prior brain injury. He was also complaining of blurred vision and headaches. Resident #49 was admitted for neuroimaging. The exam showed a decreased edema signal within the brainstem (indicating potential damage or abnormality within the brainstem region) since the prior exam. Neurology was consulted with orders to follow up outpatient. The note revealed the Neurologist felt the findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare,

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progressive brain infection that destroys cells that produce myelin, an insulating material for nerve cells). Resident #49 was discharged back to the facility on 09/20/24 with orders to follow up with neurology outpatient.

On 11/19/24 at 3:12 PM an interview was conducted with Resident #49. During the interview he stated he had gotten hit in the back of the head by his former roommate a couple of months prior. The interview revealed he was sitting in the doorway when his roommate came at him from behind. Resident #49 revealed he did not recall any details about what had occurred after he was hit and did not remember going to the hospital after the incident. He stated since the incident he felt his condition had changed and he could no longer transfer himself from his bed to the wheelchair or self-propel in his wheelchair. The interview revealed he no longer was able to use his regular wheelchair which was still located outside of his room door because he was no longer able to sit up in it. Resident #49 stated he was now confined to a specialized chair and was dependent upon staff for all activities of daily living (ADL). He stated he was unable to assist himself to the toilet to use the restroom so he was now having to wear a brief and reliant of staff to change him. He stated two nurse aides used the mechanical lift to change him.

On 11/20/24 at 11:02 AM an interview was conducted with the Medical Director (MD). The MD stated the nurse was responsible for contacting the on-call provider and notifying them of the change of condition.

On 11/20/24 at 2:51 PM an interview was conducted with the Director of Nursing. She

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stated she was notified by Unit Manager #1 early in the morning around 9:00 on 09/14/24 that Resident #49 was hit in the head by his roommate and had no injuries. The interview revealed she was unaware Resident #49 had experienced any change of condition on 09/14/24. The interview revealed if a resident had a change of condition the on-call provider should be notified immediately.

On 11/20/24 at 3:17 PM an interview was conducted with the Administrator. During the interview he stated he was notified about the altercation on a weekend day. The interview revealed the Administrator was unaware of any change of condition on the date of 09/14/24.

The Administrator was notified of the immediate jeopardy on 11/20/24 at 4:17 PM.

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

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance.

- On 09/14/24 at 9:05 AM Nurse #3 heard a loud hit or thud coming from across the unit. She then noted Resident #49's wheelchair rolling out from his room with him in the wheelchair and witnessed his roommate swing his arm with a fist and hit Resident #49 on the back of the head. Based on staff interview Resident #49 had a significant change of condition recognized by sliding out of his wheelchair, decrease in level of assistance with transfers, a decrease in bed mobility and confusion.

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- On 9/14/2024 Unit Manger #1 notified the on-call Nurse Practitioner (NP #3) at approximately 10:00 AM to report the altercation with the roommate and change in level of care needs, as more assistance was needed with transfers as it took several people to get him into the bed. The Nurse Practitioner (NP #2) arrived at the facility at approximately 3:20 PM and examined the resident related to mental status changes after an altercation with his roommate. The Nurse Practitioner arrived at the same time as EMS who had been called by the nurses and upon examination by the NP, the NP determined that the resident did not need to go out to the hospital, so EMS was turned away.

- The on-call Nurse Practitioner (NP #2) was notified at approximately 6:15 PM after Resident #49 was noted to be lying on the floor after sliding out of his wheelchair with Altered Mental Status (AMS). Resident was sent to the hospital for further evaluation due to a concern for a concussion from the hit to the back of Resident's head on 09/14/24. Hospital records indicate no acute trauma or concussion diagnosed related to the event. Resident #49 returned to the emergency room on 09/17/24 and was admitted for further neurological workup to include a Magnetic Resonance Imaging (MRI). MRI showed redemonstration of severe infratentorial and infratentorial white matter signal abnormality mildly worsened since prior MRI of 2020. It showed decreased edema signal within the brainstem, moderate ventriculomegaly, secondary to white matter volume loss. There was no acute infarction. No significant vascular disease. MRI of the Cervical Spine showed severe C4-5 left foraminal stenosis.

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- On 11/21/24 and 11/22/24, a nursing assessment was completed by the Licensed Nurses to verify all residents were currently stable and were not experiencing a change in condition requiring notification to the physician for further orders. The nursing assessment results are noted in the residents' electronic health record. The DON reviewed the results of the Licensed Nurse assessments and the 24-hour report to ensure there were no residents experiencing a change in condition requiring notification to the physician for further orders. Additionally, the DON reviewed the 24-hour report to ensure no other incidents requiring notification to the provider for which the Medical Provider had not been notified. No adverse outcomes were identified in this audit.

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

- Nurse #3 was re-educated on notification of medical provider per the policy and procedure for a resident with a change in condition on 11/22/24 based on the urgency of the situation to include but not be limited to falls, resident to resident altercations, injuries, unstable vital signs, head trauma and indwelling catheter with recurrent symptomatic urinary tract infections, or recurrent pneumonia, changes in skin color or condition.

- All licensed nurses, agency/contract staff, and all newly hired licensed nursing employees along with Certified Nurse Aides will be educated on proper notifications to the Medical Provider or to the On Call Provider after hours and on weekends when a resident has a change in

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condition or incident, immediately after the incident or immediately at the time when a change in condition occurs. The On Call After Hours provider numbers are posted at each nurses' station. Education will be completed by the DON/Nurse Manager on 11/22/2024. Nursing staff not educated by 11/22/2024 will be educated prior to the start of their next scheduled shift. This education will be completed in person or by telephone. Education for newly hired staff will be completed by the Director of Nursing/Nurse Manager during the orientation period. Staff who were not educated on 11/22/2024 either in person or by telephone will be educated prior to the start of their next scheduled shift. The DON is responsible for tracking staff who still require education. The DON/Licensed Nurse Manager will provide education to staff not educated by 11-22-24 prior to the start of the next scheduled shift. DON and Licensed Nurse Manager were notified of this responsibility on 11-22-24.

The Administrator will be responsible for the completion of the immediate jeopardy removal plan.

The immediate jeopardy removal date is 11/23/2024.

On 10/27/22, the credible allegation of immediate jeopardy removal date of 11/23/24 was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on proper notifications to the Medical Provider or to the On Call Provider after hours and on weekends when a resident has a change in condition or incident, immediately after the incident or immediately at

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F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		12/18/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 23 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to protect Resident #67's financial privacy. This practice affected 1 of 1 resident reviewed for privacy (Resident #67). The findings included: Resident #67 was admitted to the facility on 6/25/24. An observation was completed on 11/20/24 at 10:45 AM of a bulletin board in the West Hall common area. The bulletin board had a sign-up sheet for the beauty/barber shop and a price list for all services in the beauty/barber shop. The sign-up list had Resident #67's name with a price owed of $15. Multiple staff members, visitors, and residents were observed walking by the bulletin board. An interview with Nurse Aide #1 on 11/21/24 at 12:50 PM revealed the beauty/barber shop sign-up sheet had been on the bulletin board for many weeks with Resident #67's name and debt amount on it. She stated that no one ever utilized the sign-up sheet and was unsure of when the hairdresser was scheduled to come to the facility. An interview with the Activity Director on 11/22/24 at 9:27 AM revealed the hairdresser was at the facility the previous week. She stated each unit has a sign-up sheet and a price list. Staff had been educated to write resident's names on the list if they wanted to visit the beauty/barber shop. The Activity Director further revealed she	F 583	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F583 1)Beauty shop sign-up sheet was removed from bulletin board on 11/22/2024. 2)Residents who receive services from the beautician have the potential to be affected. On 11/22/2024 the Director of Nursing audited all bulletin boards throughout facility for residents private information, including financial information. No further areas of concerns were noted. 3)On 12/17/2024 the Director of Nursing re-educated the facility Beautician and Activities Director on protecting residents' privacy, including privacy of financial records. The Director of Nursing/Designee	

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	345489	A. BUILDING _____ B. WING _____	C 11/27/2024

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F 583	Continued From page 24 coordinated with the Business Office Manager to make sure each resident had enough funds to pay for the requested service. She stated she had no knowledge of any debts posted on the sheet, as the staff was educated only list names of residents who were requesting services. The Activity Director further explained she did not write the amount owed on the sign-up sheet and did not know who did. An additional observation was conducted on 11/22/24 at 9:38 AM and revealed the sign-up sheet with Resident #67's name and owed amount of $15 was visible to staff members, residents, and visitors walking by. An interview with the Business Office Manager on 11/27/24 at 10:19 AM revealed the Activity Director coordinated with the hairdresser and he would alert them if there were funds in the resident's accounts. Services would then be rendered. The Business Office Manager was not aware of a sign-up sheet in the common area. An interview with the Administrator was completed on 11/27/24 at 11:26 AM. He stated Resident #67's name and an amount owed for a service rendered should not be visible in a common area.	F 583	re-education for all staff, including Nursing staff, Housekeeping, Laundry, Activities, Administrative staff, including agency staff, on protecting residents' privacy, including privacy of financial records. This education was completed on 12/17/2024. This education will be added to the facility orientation program, and will include any new agency staff. 4)The Administrator/Designee will audit all facility bulletin boards weekly for 12 weeks to ensure resident private information, including financial information is not posted. The Administrator or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		11/29/24

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F 600	Continued From page 25 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, facility staff, Nurse Practitioner (NP), Medical Director (MD), and Physician Assistant (PA) interviews, the facility failed to protect a resident's right to be from physical abuse (Resident #49). On 09/14/24 at approximately 9:00 AM Nurse #3 heard a loud hit or thud coming from across the unit and then observed Resident #49 rolling out of his room in his wheelchair and witnessed Resident #79 swinging his arm with a fist and hit Resident #49 on the back of the head. Resident #49 was noted to slump over in his wheelchair and have a loss of consciousness for a few seconds before opening his eyes and requesting to go outside and smoke. Resident #49 had a history of a traumatic brain injury and immediately after being hit in the head by Resident #79 he was noted to have a change of condition as evidenced by a change in level of assistance needed for transfer and bed mobility changed, confusion and inability to self-propel in his wheelchair. Later in the day Resident #49 slid out of wheelchair to the floor and was assessed with worsening generalized weakness and concern for a concussion. Emergency Medical Services (EMS) was dispatched on 9/14/24 at 6:31 PM and Resident #49 was taken to the hospital for evaluation. A Computed Tomography	F 600	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F600 On 09/14/2024, at approximately 9:05 AM Resident #49 was separated from his roommate by the nurse and was assessed by the nurse. Resident #49 was then moved to another room away from the roommate to ensure their safety. The 15-minute safety checks are done by nursing staff to ensure residents are visualized and placed and not in harm's way. The 15-minute safety checks were initiated for both Resident #49 and his roommate. On 09/14/2024, Resident #49 and the roommate had a skin check performed	

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F 600	Continued From page 26	F 600		

(CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms. Resident #49 returned to the hospital on 9/17/24 for evaluation of acute chronic left-sided weakness, lightheadedness, blurred vision and headaches. Resident #49 was admitted for neuroimaging (brain scanning). The Neurologist felt the findings could represent post concussive changes and Resident #49 was discharged back to the facility on 09/20/24 with orders to follow up with neurology outpatient. At the time of the survey, Resident #49 reported he felt his condition had changed since the incident and noted he was now confined to a specialized chair and was dependent upon staff for all activities of daily living and required the use of mechanical lift for transfers. The deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #49).

Immediate Jeopardy began on 09/14/24 when Resident #49 who had a history of a traumatic brain injury was hit with a closed fist in the back of the head by Resident #79. The immediate jeopardy was removed on 11/23/24 when the facility implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective.

The findings included:

Resident #49 was a 38-year-old admitted to the facility on 10/18/2023 with a diagnosis of

by a licensed nurse status post the event to check for apparent injuries without findings.
On 9/14/2024 at 7:00 PM the nurse called the Nurse Practitioner gave the order to send Resident #49 out to the hospital related to the resident sliding out of his chair and in conjunction with significant changes in condition related to Resident #49's altered mental status, and increased need for assistance with transfer mobility and bed mobility.

On 11/22/2024 the Nurse Manager and the Social Services Director completed interviews with residents with a Brief Interview for Mental Status (BIMS) of 13 and above were interviewed to ensure no abuse or neglect. On 11/21/2024, current residents with a Brief Interview for Mental Status (BIMS) of 12 and below had skin checks performed by a licensed nurse and documented on a skin inspection sheet, to ensure no suspicious injuries or indication of abuse or neglect. On 11/22/2024, the Administrator and the Director of Nursing reviewed the incident log for the past 30 days for any other potential abuse allegations needing to be self-reported

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F 600	Continued From page 27 traumatic brain injury (TBI). A review of Resident #49's quarterly Minimum Data Set assessment dated 07/26/24 revealed he was cognitively intact. Resident #49 was coded as independent for eating and putting on/ taking off footwear. He required set up or clean up assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene. Resident #49 required supervision assistance for chair to bed transfers, toileting transfers, tub/shower transfers and lying to sitting on the side of the bed. The resident was noted to be independent for rolling left and right while in bed. Resident #49 was continent of bowel and bladder during the assessment period and was documented to have no behaviors. Resident #79 was a 40-year-old admitted to the facility on 06/15/23 with a diagnosis of TBI. A review of Resident #79's quarterly Minimum Data Set assessment dated 09/07/24 revealed he was cognitively intact. Resident #79 was coded as independent for all activities of daily living (ADL) including eating, toileting, oral hygiene, shower/bathe self, upper body dressing, lower body dressing and all transfers. He was coded as using a cane to ambulate during the assessment period. Resident #79 was documented to have no behaviors. A review of the facility's investigation report initiated on 09/14/24 at 9:05 AM by the Administrator revealed Resident #49 was hit on the back of his neck/head by his roommate. After the nurse assessed Resident #49, he was noted with no injuries and the residents were	F 600	to the state of North Carolina without any further instances noted. On 11/22/2024, current residents with targeted physical behaviors care plans and behavior monitoring tools were reviewed and updated as needed by the Interdisciplinary Team to ensure interventions are in place for safety. On 11/21/2024, the Regional Director of Clinical Services reviewed the policy with and completed re-education of the facility's policy and procedures for abuse and neglect with the Administrator and the Director of Nursing to ensure understanding with a verbal return demonstration as to the types of abuse and neglect to include but not be limited to delay of care and treatment or sending a resident to a higher level of care when they have a significant change in condition. Additionally, education included what to do if you witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator. On 11/22/2024, the Director of Nursing and Nurse Managers completed re-education with all current staff, including	

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F 600	Continued From page 28 immediately separated by moving Resident #49 to another room. Staff were briefed on the incident and monitored the residents every 15 minutes to avoid further incidents. Resident #49's roommate had stated he hit the resident because he was trying to exit the room and Resident #49 was blocking the doorway with his wheelchair. A nursing note written by Nurse #3 dated 09/14/24 at 10:11 AM revealed she heard hitting noises and turned around to observe Resident #49 get hit in the head by his roommate. The note revealed the residents were separated and assessed for injuries. Resident #49's vital signs were the following: blood pressure 138/66, pulse 72, temperature 97.9, respirations 20, oxygen saturation level 96% on room air. The resident was noted with no signs of acute distress at the time of the incident and no complaints of pain. Redness was noted to the back of the resident's neck. The residents Responsible Party, Director of Nursing and on call Nurse Practitioner were notified. New orders were obtained for a psychological evaluation of Resident #79 and every 15-minute monitoring for a duration of 24 hours. On 11/19/24 at 11:38 AM an interview was conducted with Nurse #3. Nurse #3 stated on 09/14/24 around 9:00 AM she heard a loud hit or thud coming from across the unit. She then saw Resident #49 rolling out from his room in his wheelchair and witnessed (Resident #79) who was cognitively intact, swinging his arm with a fist and hit Resident #49 at the back of the head making a second thud sound as his fist hit the back of Resident #49's head. Resident #49 immediately slumped over in his wheelchair and regained consciousness within a couple of	F 600	Dietary, Housekeeping, Laundry, administration, Maintenance, Social Services, Therapy, Activities, Department Managers, Nursing, including Licensed Nurses, Medication Aides and Certified Nursing Assistants, including agency staff on the facility's policy and procedure for abuse and neglect to ensure understanding with a verbal return demonstration as to the types of abuse and neglect to include but not be limited to delay of care and treatment or sending a resident to a higher level of care when they have a significant change in condition. Additionally, education included what to do if you witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator. This education for the nursing staff will be the responsibility of the DON/Licensed Nurse Manager for current staff. Staff who were not educated on 11/22/2024 either in person or by telephone will be educated prior to the start of their next scheduled shift. The DON was responsible for tracking	

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F 600	Continued From page 29 seconds after she got to him to assess his condition. She stated she saw redness at the back of Resident #49's head and neck area. When Resident #49 came to he asked to go outside to smoke so Nurse Aide (NA) #2 took him to the smoking area. Nurse #3 indicated she had obtained initial vital signs on the resident which were within normal range, assessed him and the Unit Manager notified the Nurse Practitioner of what had occurred. Nurse #3 explained when Resident #49 was moved from her hall around 10:00 AM, she no longer was his nurse and did not see him again that day. On 11/21/24 at 12:32 PM an interview was conducted with Scheduler #1. She stated she was working as the Manager on Duty on 09/14/24. Scheduler #1 stated her office door was open and she overheard a nurse screaming for help. When she went out into the hall, she saw Nurse #3 and went to her. Scheduler #1 stated Resident #49 sitting in his wheelchair slumped over and was unconscious for approximately a minute. Nurse #3 explained to her that he had just been hit in the back of the head by Resident #79. When he initially woke up after being hit and "came to", his abilities were not the same, he was using his hands but nothing else like he had before. She stated he was no longer able to self-propel himself in the hallway as he had done that morning or self-transfer to bed. After separating the residents, she stated she notified the Unit Manager #1 via the facility paging system and Nurse #3 called the Director of Nursing. Scheduler #1 stated Resident #49 was taken to the smoking area by NA#2 because he stated he wanted to go smoke. She stated Resident #49 immediately seemed spaced out by responding slowly when spoken to and not thinking clearly.	F 600	staff who still require education. The DON/Licensed Nurse Manager will provided education to staff who were not educated by 11/22/24 prior to the start of the next scheduled shift. This education was completed on 11/22/2024 The Director of Nursing, Administrator or Nurse manager will be responsible for this education going forward and will be added to the facility orientation program for all new hired staff, including agency staff. The Director of Nursing or designee will review the 24-hour report 5 times a week for 12 weeks to ensure residents that are identified to have behaviors have care plans, behavior monitoring tools and interventions in place for safety for themselves and others. The Director of Nursing or designee will randomly interview 5 residents weekly for 12 weeks with a Brief Interview for Mental Status (BIMS) score of 13 or higher to ensure no concerns for abuse or neglect. The Director of Nursing or designee will randomly interview 3 staff members weekly	

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F 600	Continued From page 30 The interview revealed Resident #49 started trying to go in the wrong direction and had to be redirected by staff. When they took him to his new room, it took Scheduler #1, NA #2 and Nurse #3 to all assist him into the bed. Scheduler #1 told Nurse #3 she would need to complete neurological assessments. She stated they were so concerned with Resident #49's condition they had placed a fall mat under his bed because they felt like he may have a fall from the bed due to his state of immobility. On 11/21/24 at 9:06 AM an interview was conducted with Unit Manager (UM) #1. During the interview she stated on 09/14/24 around 9:00 AM she was paged on the overhead call system to come to Resident #49's room. Upon arrival Nurse #3 told her Resident #49 had been hit on the back of his head by Resident #79. She stated she looked at the resident and he was able to respond to her. She had them remove Resident #49 from the room and contacted the Director of Nursing (DON) who stated she needed to notify the resident's family and the provider on call. She stated the provider on call (NP #3) asked her how the resident was doing, and she stated it was her first time laying eyes on him, and he seemed okay. UM #1 recalled they immediately moved Resident #49 to a room in another hall around 10:00 AM. Unit Manager #1 stated she was rounding later in the day and saw Resident #49's call light on, she stated he was trying to transfer himself from the wheelchair to the toilet which the NA said he was normally able to do. She stated she had to get two other staff members to assist due to his weakness. On 11/19/24 at 12:52 PM an interview was conducted with Nurse Aide (NA) #2. NA #2 stated	F 600	for 12 weeks on abuse and neglect to ensure understanding of types of abuse, witnessed abuse or neglect and timely reporting. The Director of Nursing or designees will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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she was responsible for Resident #49 on 09/14/24 during first shift (7:00 AM to 3:00 PM). She stated she did not witness the incident but was notified of what had happened by Nurse #3. NA #2 recalled she was told by Nurse #3 to move Resident #49's belongings out of his room into a new room on another unit. NA #2 indicated she moved Resident #49's belongings and assisted him from the smoking area to his new room around 10:00 AM and assisted him into the bed which was different from that morning. Earlier in morning, he was able to transfer himself. NA #2 stated she had discussed Resident #49's change of condition with both Nurse #3 and Nurse #4 as soon as she assisted Resident #39 into his bed in the new room that morning. NA #2 stated she immediately noticed a difference in the way Resident #49 was responding and moving. NA #2 stated Resident #49 could not assist her at all for bed mobility and had to remain in bed for the rest of her shift. NA #2 explained she decided to continue to provide care to the resident despite him being on another unit due to staffing concerns. NA #2 indicated Resident #49 had gone from being able to transfer himself that morning to being unable to roll from left to right in the bed following the incident. For the remainder of the shift Resident #49 was provided with incontinent care in bed, which was a change of condition. NA #2 also noted Resident #49 seemed slow to respond when she spoke to him.

On 11/19/24 at 2:00 PM an interview was conducted with NA #1. During the interview she stated she came on shift at 3:00 PM and received report from NA #2. She and the Unit Manager #1 assisted Resident #49 to his wheelchair because his legs were dangling off of the bed around 4:00 PM. NA #1 noted Resident #49 to be disoriented,

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leaning back in his wheelchair, sliding out of his wheelchair and overall, not looking like he typically did, sitting up, self-propelling himself in a regular wheelchair in the hallway. NA #1 indicated she was changing Resident #49's brief while he was in bed, which was a change as he could usually transfer himself to the bathroom. NA #1 remembered having to assist him back up in his wheelchair during that evening and he eventually slid completely out of his wheelchair into the floor in the hallway around 6:30 to 7:00 PM.

On 11/19/24 at 2:49 PM an interview was conducted with Nurse #4. She stated she was in the building on 09/14/24 during the first shift (7:00 AM to 3:00 PM) and second shift (3:00 PM to 11:00 PM). The interview revealed Resident #49 was moved to her hall following an altercation with Resident #79 during which Resident #79 hit Resident #49 on the back of his head. She stated she assumed Resident #49's care for second shift at 3:00 PM. The interview revealed Resident #49 was noted to be in bed, which was not usual because he was typically up and out in the facility in the hallway during the day. Nurse #4 stated the NA #1 and NA #2 were telling her he was experiencing a significant change of condition from his normal baseline by being in bed, a decrease in mobility, decreased alertness and incontinence throughout the day. Nurse #4 explained Resident #49 was gotten up to his wheelchair for the supper meal and he kept sliding out of the wheelchair and Nurse #4 had to obtain other staff members to assist her to pull him up in his chair. Nurse #4 indicated around 6:30 PM Resident #49 was noted to fall out of his wheelchair onto the floor in the hallway.

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A late entry incident report dated 09/14/24 at 11:02 PM written by Nurse #4 revealed Resident #49 had experienced a fall and was found in the hallway sitting on his bottom around 6:30 PM. Resident #49 stated he had slid off his wheelchair. No injuries were observed however the resident was sent to the hospital due to recent change in cognition.

On 11/19/24 at 3:12 PM an interview was conducted with Resident #49. During the interview Resident #49 stated he had gotten hit in the back of the head by Resident #79 a couple of months prior. The interview revealed he was sitting in the doorway when Resident #79 came at him from behind. Resident #49 revealed he did not recall any details about what had occurred after he was hit and did not remember going to the hospital after the incident. He felt his condition had changed since the incident and noted he could no longer transfer himself from his bed to the wheelchair or self-propel in his wheelchair. Resident #49 revealed he was no longer able to use his regular wheelchair, which was still located outside of his room, because he was no longer able to sit up in it. Resident #49 stated he was now confined to a specialized chair and was dependent upon staff for all activities of daily living and required the use of mechanical life for transfers. He stated he was unable to transfer himself to the toilet to use the restroom and was having to wear a brief, urinate on himself, and reliant on staff to change him.

A Nurse Practitioner note written by NP #2 on 09/15/24 as late entry for 09/14/24 revealed she was asked to see Resident #49 for altered mental status after an altercation in which the resident ended up on the floor knocked out cold, he did

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not hit his head and regained consciousness right away but now seen with altered mental status. At the time of the assessment, although he was able to follow simple commands, he was noted to have worsening generalized weakness "drop in extremity" sitting in the chair. She was noted to be concerned for a concussion and escalated the resident to the emergency room for an evaluation and management.

On 11/22/24 at 9:14 AM an interview was conducted with Nurse Practitioner #2. She stated she was an in-house provider that rounded in the facility on the weekends. She stated she remembered evaluating Resident #49 while he was sitting in a chair, but NP #3 was originally notified that morning about an altercation. NP #2 stated staff did tell her the resident had been hit in the head by his roommate and had experienced altered mental status. However, she did not witness the incident and therefore it was only hearsay. She stated when the resident became unstable and fell, she sent him out.

Review of the Emergency Medical Services (EMS) dispatch log for the facility on 09/14/24 revealed they were notified to respond for Resident #49 at 6:31 PM due to a fall in which the resident slipped from his chair to the floor. EMS arrived at the facility and transported Resident #49 to the hospital.

EMS records dated 09/14/24 revealed they were dispatched to the facility with a chief complaint of increased weakness and a fall after an assault earlier in the morning. The resident had a history of TBI and wanted to be evaluated. Resident #49 stated he was hit in the head by Resident #79 earlier in the morning around 9:00 AM. He stated

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Resident #79 used his fist to hit him in the head and denied loss of consciousness. Staff, however, did say the resident lost consciousness. The resident was cleared initially by his facility physician to stay at the facility and not be transported to the hospital. Around 6:30 PM Resident #49 was sitting in his wheelchair, when he tried to reposition himself, he had increased weakness that caused him to slide down the chair onto the floor. The resident was noted to be on the floor when the medic arrived. Resident #49 was mechanically lifted into the medic's stretcher. EMS documented the resident's vital signs at 6:52 PM to include the following: blood pressure 120/76, pulse 70 beats per minute (bpm), respirations 16, oxygen saturation level 94% (normal >92%). Resident #46 was noted to be oriented to person, place and time. The resident stated to EMS he felt safe at the facility, however, would like a new roommate. The note read, "Patient is requesting we transport him to the hospital for further evaluation."

Hospital records dated 09/14/24 revealed Resident #49 was evaluated on this date after sliding out of his wheelchair around 6:30 PM. Per the Medic the resident was also punched in the head by his roommate earlier in the morning around 9:30 AM but cleared by the facility. The residents' diagnoses included fall, closed head injury and generalized weakness. A Computed Tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms.

A nursing progress note dated 09/15/24 at 6:55 AM revealed Resident #49 had returned to the

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facility from the hospital by EMS transport. Resident #49 was noted to be in no acute distress or discomfort.

A Nurse Practitioner note dated 09/16/24 written by NP #1 revealed she was asked to evaluate Resident #49 on this date by the Director of Nursing (DON) due to the resident being sent to the Emergency Department (ED) after he was forcefully hit in the head by his roommate and had experienced a couple of falls since the incident. Resident #49 was noted to have been evaluated for a close head injury while in the hospital. At the time of her assessment the resident was noted to be in a stable condition with no complaints of pain or weakness. During the evaluation he was noted to be in bed resting with no acute distress.

On 11/19/24 at 3:36 PM an interview was conducted with Nurse Practitioner #1. During the interview she stated Resident #49 was sent to the hospital on 09/14/24 following a fall in the facility. She stated she was not in the facility or on call the weekend the incident occurred but learned of the altercation the following Monday after returning to the facility. NP #1 stated Resident #49 had experienced two falls after returning back to the facility from the hospital and she was asked to evaluate him on 09/16/24 following the second fall. Resident #49 was in no distress during her evaluation. The interview revealed Resident #49 started experiencing headache, weakness and lightheadedness on 09/17/24 while she was in the building and was sent back to the hospital. He was discharged back to the facility on 09/20/24. NP #1 stated she had written a progress note on 10/21/24 discussing the hospital course and they had conducted a neurological

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work up while the resident was in the hospital. She stated the hospital notes did discuss the resident could have had post concussive findings meaning it was possible he had experienced a concussion from the incident, but they were unable to determine if it was that or a past misdiagnosis. NP #1 stated Resident #49 is now in a specialized wheelchair that leaned back unlike the chair he was in prior to the incident which was a regular wheelchair. She stated once he came back from the hospital, he was slow to respond with occasional headaches and was not as active as he was prior to the incident. She stated it was possible the effects he has experienced could be from the altercation, but the resident had other conditions that could have contributed to the changes he had experienced.

Hospital records dated 09/17/24 revealed Resident #49 presented to the hospital for evaluation of acute chronic left-sided weakness. The resident was reported to have been punched in the head by a roommate 3 days prior. He was originally evaluated in the Emergency Department on 09/14/24 and cleared for discharge. He presented back to the hospital complaining of lightheadedness and felt that his left side was weaker than his baseline from prior brain injury. He was also complaining of blurred vision and headaches. Resident #49 was admitted for neuroimaging. The exam showed a decreased edema signal within the brainstem (indicating potential damage or abnormality within the brainstem region) since the prior exam. Neurology was consulted with orders to follow up outpatient. The note revealed the Neurologist felt the findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare,

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progress brain infection that destroys cells that produce myelin, an insulating material for nerve cells). The resident's hospital course included a full stroke workup resulting in no findings of a stroke, Physical Therapy and Occupational Therapy evaluation, lab workup and inpatient neurology evaluation. Resident #49 was discharged back to the facility on 09/20/24 with orders to follow up with neurology outpatient.

On 11/20/24 at 11:02 PM an interview was conducted with the Medical Director (MD). The MD stated she had only been in the facility since September 2024 and was not familiar with Resident #49's prior state. She stated she knew of the incident occurring, but the on-call Nurse Practitioner was notified since the incident occurred on a weekend. The MD indicated the resident was sent to the hospital following a fall in the hallway and his CT at the hospital was negative, so he was sent back to the facility. The interview revealed Resident #49 continued to have symptoms of a concussion, so he was sent to the hospital for a reevaluation on 09/17/24. The MD explained it could take a couple of days for symptoms of a concussion to appear. She stated at the hospital there were changes from his previous MRI with a decreased signal to the brainstem which she felt couldn't have happened from a hit to the resident's head. Neurology was consulted while Resident #49 was hospitalized and mentioned post concussive findings in their note, however they were also ruling out a possible misdiagnosis in the past. The interview further revealed concussion symptoms would have included lightheadedness, light sensitivity and blurred vision, all which Resident #49 was noted to have during his 09/17/24 hospitalization.

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On 11/27/24 at 2:05 PM an interview was conducted with the Neurologist Physician Assistant. She stated she had evaluated Resident #49 during his follow up appointment on 10/18/24. She stated the resident was being seen due to an abnormal brain MRI, white matter disease, left side numbness, incoordination and weakness. The PA stated she had only seen the resident during a one-time snapshot, and it is very hard to say the findings came directly from the altercation. She stated she had ordered follow up blood work, a lumbar puncture and was going to be reevaluating Resident #49 at the first of the year to see if there was a possible relationship between the altercation and the changes the resident has experienced.

On 11/20/24 at 2:51 PM an interview was conducted with the Director of Nursing (DON). The DON stated she was notified early in the morning around 9:00 on 09/14/24 that Resident #49 was hit in the head by Resident #79. She stated Resident #49 was sitting in his wheelchair in the doorway of the room and Resident #79 wanted to get out of the room.

On 11/20/24 at 3:17 PM an interview was conducted with the Administrator. During the interview he stated he was notified about the altercation on a weekend day. Staff had told him Resident #79 had "popped" Resident #49 on the back of the neck. The Administrator stated based on his understanding of what had happened that day staff did not make it seem like Resident #49 was hit hard by Resident #79. He was unaware Resident #79 used a fist to swing and hit Resident #49 in the back of the head.

The Administrator was notified of the Immediate

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Jeopardy on 11/20/24 at 4:17 PM.

The facility provided the following Credible Allegation of immediate jeopardy removal.

Plan for Removal of Immediate Jeopardy for F600

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

The facility failed to protect Resident #49's rights to be from physical abuse. On 09/14/2024 at 9:05 AM Nurse #1 heard a loud hit or thud coming from across the unit. She then noted Resident #49's wheelchair rolling out from his room with the resident in the wheelchair and witnessed his roommate who was cognitively intact swing his arm with a fist and hit Resident #49 in the back of the head. Resident #49 was noted to slump over in his wheelchair for a few seconds before opening his eyes and requesting to go outside and smoke. Resident #49 had a history of traumatic brain injury. On 9/14/2024 at approximately 3:20pm, Resident #49 was seen by the Nurse Practitioner at the facility at the same time that Emergency Medical Services arrived. After assessing the resident, the Nurse Practitioner did not feel the resident needed to go to the hospital for further treatment despite the knowledge that Resident #49 had an altercation with the roommate and was struck in head with a significant decline from baseline as reported by several staff during the observation period.

On 09/14/2024, at approximately 9:05 AM Resident #49 was separated from his roommate by the nurse and was assessed by the nurse.

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Resident #49 was then moved to another room away from the roommate to ensure their safety. The 15-minute safety checks are done by nursing staff to ensure residents are visualized and placed and not in harm's way. The 15-minute safety checks were initiated for both Resident #49 and his roommate.

On 09/14/2024, Resident #49 and the roommate had a skin check performed by a licensed nurse status post the event to check for apparent injuries without findings.
On 9/14/2024 at 7:00 PM the nurse called the Nurse Practitioner gave the order to send Resident #49 out to the hospital related to the resident sliding out of his chair and in conjunction with significant changes in condition related to Resident #49's altered mental status, and increased need for assistance with transfer mobility and bed mobility.

On 11/22/2024 the Nurse Manager and the Social Services Director completed interviews with residents with a Brief Interview for Mental Status (BIMS) of 13 and above were interviewed to ensure no abuse or neglect.

On 11/21/2024, current residents with a Brief Interview for Mental Status (BIMS) of 12 and below had skin checks performed by a licensed nurse and documented on a skin inspection sheet, to ensure no suspicious injuries or indication of abuse or neglect.

On 11/22/2024, the Administrator and the Director of Clinical Services reviewed the incident log for the past 30 days for any other potential abuse allegations needing to be self-reported to the state of North Carolina without any further

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instances noted.

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

On 11/22/2024, current residents with targeted physical behaviors of becoming aggressive to others were identified by the Interdisciplinary Team to include the Administrator, Director of Nursing, Medical Director, Nurse Practitioner, Social Services Director, Activities Director, Therapy Director.

On 11/22/2024, current residents with targeted physical behaviors care plans and behavior monitoring tools were reviewed and updated as needed by the Interdisciplinary Team to ensure interventions are in place for safety.

On 11/21/2024, the Regional Director of Clinical Services reviewed the policy with and completed re-education of the facility's policy and procedures for abuse and neglect with the Administrator and the Director of Nursing to ensure understanding with a verbal return demonstration as to the types of abuse and neglect to include but not be limited to delay of care and treatment or sending a resident to a higher level of care when they have a significant change in condition. Additionally, education included what to do if you witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator.

On 11/22/2024, the Director of Nursing and Nurse

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Managers completed re-education with all current staff, including Dietary, Housekeeping, Laundry, administration, Maintenance, Social Services, Therapy, Activities, Department Managers, Nursing, including Licensed Nurses, Medication Aides and Certified Nursing Assistants, including agency staff on the facility's policy and procedure for abuse and neglect to ensure understanding with a verbal return demonstration as to the types of abuse and neglect to include but not be limited to delay of care and treatment or sending a resident to a higher level of care when they have a significant change in condition. Additionally, education included what to do if you witness abuse and neglect, when to report abuse and neglect, to whom to report abuse and neglect and the designated facility abuse coordinator, who is the facility administrator. This education for the nursing staff will be the responsibility of the DON/Licensed Nurse Manager for current staff. Staff who were not educated on 11/22/2024 either in person or by telephone will be educated prior to the start of their next scheduled shift. The DON is responsible for tracking staff who still require education. The DON/Licensed Nurse Manager will provide education to staff not educated by 11-22-24 prior to the start of the next scheduled shift. DON and Licensed Nurse Manager were notified of this responsibility on 11-22-24.

Education will be done by the DON/RN Nurse Manager during the orientation period for any newly hired staff ongoing, including agency staff for abuse and neglect.

An Ad-Hoc Quality Assurance Performance Improvement Committee was held on 11/21/2024, which included the Regional Clinical Director, Medical Director, the Director of

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F 600	Continued From page 44 Nursing, Administrator, Maintenance Director, Unit Managers, Social Service Director, Activities Director, Rehab Program Manager and a Certified Nursing Assistant to formulate and approve a plan of correction for the deficient practice. The Administrator will be responsible for the completion of the corrective action plan. Alleged date of IJ removal: 11/23/2024 On 10/27/22, the credible allegation of Immediate Jeopardy removal date of 11/23/24 was validated by onsite verification through facility staff interviews. The interviewed staff across all disciplines including Dietary, Housekeeping, Laundry, administration, Maintenance, Social Services, Therapy, Activities, Department Managers, Nursing, including Licensed Nurses, Medication Aides and Certified Nursing Assistants, and agency staff on the facility's policy and procedure for abuse and neglect revealed they had received in-service training regarding spotting, identifying, and reporting abuse. Records were reviewed of residents identified with targeted physical behaviors. A sample of residents were interviewed to ensure they had been asked about abuse and neglect by the facility. Skin assessments were reviewed for residents with a BIMS score of less than 12. The IJ removal date of 11/23/24 was validated.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		12/18/24

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F 610	Continued From page 45 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a thorough investigation of an allegation of resident-to-resident abuse for 2 of 3 residents reviewed for abuse (Resident #49 and Resident #79). Findings included: The facility's "Abuse Investigation and Reporting " policy revised in July 2017 read in part as follows: "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/ or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The role of the investigator included: - Review the completed documentation forms. - Resident the residents medical record to	F 610	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F610 The facility completed an investigation for residents #49 and #79 in regard to resident to resident altercation on 9/14/2024. The facility will thoroughly investigate all alleged violations and have evidence by documentation, staff interviews,	

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F 610	Continued From page 46 determine events leading up to the incident. - Interview the person reporting the incident. - Interview any witnesses to the incident. - Interview the resident. - Interview the residents Attending Physician as needed to determine the resident's current level of cognitive function. - Interview the resident's roommate, family members and visitors. - Interview other residents to whom the accused employee provided care or services. - Review all events leading up to the alleged incident. The following guidelines will be used when conducting interviews: - Each interview will be conducted separately in a private location. - Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. Resident #49 was a 38-year-old admitted to the facility on 10/18/2023 with a diagnosis of traumatic brain injury (TBI). A review of Resident #49's quarterly Minimum Data Set assessment dated 07/26/24 revealed he was cognitively intact. Resident #79 was a 40-year-old admitted to the facility on 06/15/23 with a diagnosis of TBI. A review of Resident #79's quarterly Minimum Data Set assessment dated 09/07/24 revealed he was cognitively intact. Review of a 5-day Investigation Report dated	F 610	chart review and statements, to prevent further potential abuse, neglect, exploitation, or mistreatment, including resident to resident abuse while the investigation is in progress. All of which will be done in a timely manner that follow state regulations. All residents who had reports of abuse, neglect, resident to resident abuse, exploitation or mistreatment have the potential to be affected. On 12/13/2024 the Regional Clinical Director reviewed all facility reports of abuse, neglect, resident to resident abuse, exploitation or mistreatment for the last 30 days to ensure investigations were completed thoroughly. There were no further concerns identified. The Regional Clinical Director re-educated the Director of Nursing and the Administrator on conducting a thorough investigation, to include documentation, chart reviews, staff and resident statements. This education was completed on 12/13/2024. The Director of Nursing/designee re-educated all staff on abuse, including resident to	

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	345489	A. BUILDING _____ B. WING _____	C 11/27/2024

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F 610	Continued From page 47 09/20/24 revealed the allegation/incident type being investigated was "Resident Abuse" that occurred on 09/14/24. The report read in part; Resident #79 hit Resident #49 in the back. The two residents are roommates and got into an argument. After the nurse assessed, there was no injury, and the residents were immediately separated by moving Resident #49 to another room. Staff were briefed and will continue to monitor the residents every 15 minutes to avoid further incidents. Labs were submitted on Resident #79 to rule out a urinary tract infection. Review of the facility investigation file revealed a typed "summary" of the incident that occurred on 09/14/24 and read in part, " Resident #79 hit his roommate Resident #49 on 09/14/24 at approximately 8:46 AM on the back of his neck/head. The nurse noted no injury to either resident upon skin sweeps performed on 09/14/24 for Resident #49 and Resident #79. Resident #79 stated that he hit Resident #49 because he was trying to exit the room and Resident #49 was blocking the doorway with his wheelchair. Both residents were immediately separated by staff and a room changed was completed for Resident #49. Resident #49 and Resident #79 were both placed on safety checks. The Physician was notified of the incident involving the residents. Law enforcement was notified of the incident. Current staff across departments were re-educated on abuse and neglect. The interdisciplinary team reviewed/updated the plan of care for both residents after the incident. The conclusion: the incident was unsubstantiated as abuse; it was an impulsive act and was without intent. On 11/20/24 at 2:51 PM an interview was	F 610	resident abuse, neglect, exploitation or mistreatment and timely reporting. This education was completed on 12/13/2024 Any reports of abuse, resident to resident abuse, neglect, exploitation or mistreatment investigations will be reviewed by the Regional Clinical Director or designee weekly for 12 weeks to ensure a thorough investigation is completed by facility staff. This review will include documentation, record review, staff statements, and resident statements. The Regional Clinical Director or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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F 610	Continued From page 48 conducted with the Director of Nursing (DON). The DON stated she was notified early in the morning around 9:00 on 09/14/24 that Resident #49 was hit in the head by Resident #79. She stated Resident #49 was sitting in his wheelchair in the doorway of the room and Resident #79 wanted to get out of the room. The DON contacted the Administrator because she was out of town and he handled the investigation along with Unit Manager #1. A review of the facility investigation file and interview with the Administrator were conducted on 11/20/24 at 3:17 PM. The Administrator stated he was notified of the incident on a weekend day (09/14/24) by the Director of Nursing (DON) via telephone. He stated he told the DON he would handle the situation due to her being out of town. The interview revealed he asked Unit Manager #1 to complete the on-site witness interviews and obtain statements regarding the incident on 09/14/24 but they were not completed. The Administrator stated Unit Manager #1 had told him Resident #79 had "popped" Resident #49 on the back of the neck and he did not realize Resident #49 had been hit in the head. The Administrator confirmed he did not have any resident or witness statements from the date of 09/14/24 nor, were the Nurse Aides and staff involved in caring for the resident following the incident interviewed. The interview revealed the Administrator was unaware Resident #49 had experienced a change of condition following the altercation with Resident #79 and thought the resident had no injures from the altercation.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		12/20/24

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F 641	Continued From page 49 §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, observation, and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for pain (Resident #9 and Resident #69), activities of daily living (ADL) (Resident #69), and pressure ulcers (Resident #199) for 3 of 6 residents whose MDS were reviewed for accuracy. The findings included: 1. Resident #9 was admitted to the facility on 3/22/2024 with diagnoses that included chronic pain syndrome and osteoarthritis. A review of the most recent quarterly (MDS) assessment dated 8/28/2024 revealed Resident #9 had severe cognitive impairment. The pain assessment interview indicated the resident interview should be conducted; however, it was not completed, nor was the staff assessment for pain conducted. A telephone interview was completed on 11/21/2024 at 10:55 AM with MDS Coordinator #2. During the interview MDS Coordinator #2 revealed he worked remotely and did not come into the building. MDS Coordinator #2 said the pain assessments were supposed to be completed by the nurse in the facility and they had to be completed by the assessment reference date (ARD), which was the last day of the MDS review period, to be counted. He reported the pain assessment was in the computer system to be completed and if they	F 641	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F641 Resident #9s MDS (Minimum Data Set) assessment ARD (Assessment Reference Date) of 8/28/2024 was not modified, as the RAI (Resident Assessment Instrument) manual instructions for coding reads “If the resident interview should have been conducted, but was not done within the look back period of the ARD (Assessment Reference Date) (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard “no information” code (a dash “—”) entered in the Pain Assessment Interview items (J0300–J0600). Resident #69 had modifications completed for MDS (Minimum Data Set) assessment ARD (Assessment Reference Date) of 10/8/2024 To reflect accurate ADL (Activities of	

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F 641	Continued From page 50	F 641		

were not completed timely, he could not use them. MDS Coordinator #2 explained that there were spaces on the resident's medication administration record (MAR) where pain was recorded, however he could not use that information for the actual pain interview. MDS Coordinator #2 said he could only do the staff interview if the resident was unable to answer and it had to be completed by the ARD.

On 11/21/2024 at 11:40 AM a telephone interview was completed with the Regional MDS Coordinator. During the interview the Regional MDS Coordinator reported the pain assessments should have been completed by the nurses in the facility, however MDS Coordinator #2 could have read through the nurse's notes to get the information that was needed for the pain interview.

2. Resident #69 was admitted to the facility on 4/12/2024 with diagnoses of depression, neuropathy (peripheral nerve damage often causing weakness, numbness or pain usually in the hands or feet), and a diabetic ulcer to the left heel.
Review of Physician orders dated 7/15/2024 showed an order for Gabapentin (treats nerve pain) capsule 300 milligram (mg) three times a day related to a diagnosis of neuropathy.

Review of the most recent quarterly MDS assessment dated 10/8/2024 showed Resident #69 had no cognitive impairment and had no range of motion limitations. Resident #69 was marked as being dependent upon staff for eating and oral hygiene, but independent with toilet hygiene. Further review revealed Resident #69 was marked as dependent with walking 50 feet

Daily Living) status on 11/28/2024. Resident #69 MDS (Minimum Data Set) assessment ARD (Assessment Reference Date) of 10/8/2024 was not modified, as the RAI Manual instructions for coding reads "If the resident interview should have been conducted, but was not done within the look back period of the ARD (Assessment Reference Date) (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "—") entered in the Pain Assessment Interview items (J0300–J0600). Resident #199 had modification on 12/18/2024 for MDS (Minimum Data Set) assessment ARD (Assessment Reference Date) of 11/10/2024 to remove diagnosis of Stage 2 pressure ulcers and coding "yes" for being at risk of developing a pressure ulcer.

All residents have the potential to be affected. On 12/18/2024 the Regional Director of Clinical Reimbursement and Vice President Of Clinical Reimbursement completed an MDS (Minimum Data Set) audit for the last 30 days of current residents to ensure the most recent MDS (Minimum Data Set) is accurate for pain, ADL (Activities of Daily Living) accuracy and

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F 641	Continued From page 51 but was independent walking 150 feet. The pain assessment interview indicated the resident interview should be conducted; however, it was not completed. An interview and observation with Resident #69 were conducted on 11/18/2024 at 11:22 AM. During the interview Resident #69 reported she was able to walk to the bathroom while using a walker. There was a walker at the resident's bedside. Resident #69 reported she felt like she had an improvement in her ADL since admission. A telephone interview was completed on 11/21/2024 at 10:55 AM with MDS Coordinator #2. During the interview MDS Coordinator #2 revealed he worked remotely and did not come into the building. MDS Coordinator #2 said the pain assessments were supposed to be completed by the nurse in the facility and they had to be completed by the assessment reference date (ARD), which was the last day of the MDS review period, to be counted. He reported the pain assessment was in the computer system to be completed and if they were not completed timely, he could not use them. MDS Coordinator #2 explained that there were spaces on the resident's medication administration record (MAR) where pain was recorded, however he could not use that information for the actual pain interview. MDS Coordinator #2 said he could only do the staff interview if the resident was unable to answer and it had to be completed by the ARD. MDS Coordinator #2 explained the coding of ADLs was completed using nursing and nurse's aide documentation and if any discrepancies were noted he could call the facility and question the staff. MDS Coordinator #2 reported he did not call	F 641	Pressure Ulcer Staging. This audit was completed on 12/19/2024 On 12/18/2024 the Regional Director of Clinical Reimbursement re-educated the facility MDS (Minimum Data Set) Coordinators on Policy and Procedures for accuracy of MDS (Minimum Data Set) assessments. This education was completed on 12/18/2024. This education will be added the facility orientation program for all newly hired MDS (Minimum Data Set) Coordinators. The Regional Director of Clinical Reimbursement will randomly audit 10 MDS (Minimum Data Set) assessments weekly for 12 weeks to ensure accuracy of MDS (Minimum Data Set) assessments for pain assessment, ADLs (Activities of Daily Living and Pressure Ulcers. The Regional Director of Clinical Reimbursement or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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F 641	Continued From page 52	F 641		

about any discrepancies prior to completing the assessment and the coding for walking and eating for Resident #69 was not accurate.

An interview was completed with the Director of Nursing (DON) on 11/22/2024 at 10:03 AM. During the interview the DON stated she expected to see the MDS assessments completed accurately for all residents.

3. Resident #199 was readmitted to the facility on 11/4/2024 with the following diagnosis: quadriplegia and two stage 3 pressure ulcers.

A review of Resident #199's medical diagnosis list indicated Resident #199 previously had a diagnosis of Stage 2 pressure ulcer dated 1/25/2021, and a non-pressure ulcer of the back dated 6/16/2021 that had previously been resolved.

Review of a wound note dated 11/4/2024 noted Resident #199 had one stage 3 pressure ulcer to the left proximal thigh, and one stage 3 pressure ulcer to the left buttock.

Review of a quarterly MDS assessment dated 11/10/2024 showed Resident #199 was coded "No" for at risk of developing a pressure ulcer, but coded "Yes" for having one or more unhealed pressure ulcers. Three stage 3 pressure ulcers present upon admission were coded along with diagnoses of a stage 2 pressure ulcer to the right heel and a non-pressure ulcer to the back were also marked on the MDS assessment.

An observation and interview were completed with the facility Wound Nurse on 11/20/2024. During the observation there were 3 pressure

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F 641	Continued From page 53 areas noted to Resident #199's left thigh and left buttock. The Wound Nurse indicated those areas were the only areas Resident #199 had and was receiving treatment for. She also reported Resident #199 had 2 of the wounds for a while, but a new area had recently developed on the left thigh making the total amount of wounds 3. The wound nurse stated Resident #199 did not have a pressure area to his back or his right heel. A telephone interview was completed on 11/21/2024 at 10:43 PM with MDS Coordinator #1. During the interview MDS Coordinator #1 reported obsolete diagnoses should not be coded on the MDS assessment. If the resident was not receiving treatment for the diagnosis, then it should not be coded. An interview was completed with the Director of Nursing (DON) on 11/22/2024 at 10:03 AM. During the interview the DON stated she expected to see the MDS assessments completed accurately and timely for all residents.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		12/20/24

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F 656	Continued From page 54 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to develop a comprehensive person-centered care plan that addressed suprapubic urinary catheter and pressure ulcers (Resident #199), assistance with	F 656	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan	

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F 656	Continued From page 55 activities of daily living (ADL) (Resident#1), Diabetes Mellitus Type 2 therapy (Resident #1), medical conditions and high-risk medications that require monitoring (Resident #1 and Resident #9) for 3 of 13 residents whose care plans were reviewed. 1. Resident #9 was admitted to the facility on 3/22/2024. Her diagnoses included diabetes mellitus type 2 (DM), unspecified dementia, hypertension (HTN), atrial fibrillation (A-fib), depression, anxiety, pseudobulbar affect (a condition with inappropriate crying and laughing) and post-traumatic stress disorder (PTSD). Review of Resident #9's care plan dated 8/13/2024 and revised on 11/14/2024 revealed no care plans related to a diagnosis of DM or the use of antidepressant, antianxiety, anticoagulant, diuretic, or insulin medications. Review of Physician orders showed the following orders in place: 7/22/2024 - Insulin detemir insulin pen subcutaneous solution 100 units/milliliters (ml), inject 30 units subcutaneously in the morning 8/15/2024 - Sertraline 50 milligrams (mg) (antidepressant medication), give 1.5 tablet by mouth one time a day for anxiety 10/2/2024 - Lorazepam 0.5 mg (antianxiety medication), give 1 tablet three times a day for agitation 10/14/2024 - Torsemide 10 mg (diuretic medication to help remove excess fluid), give one time a day for HTN and hold if systolic blood	F 656	of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F656 1)The care plan for Residents #9 was updated to reflect diagnosis of DM, and use of antidepressant, antianxiety, anticoagulant, diuretic and insulin medications. The care plan for Resident #199 was updated to reflect indwelling (suprapubic) catheter and current pressure ulcers. The care plan for Resident #1 was updated to reflect Psychotropic and Diabetic medications, and ADL assistance. 2)All residents have the potential to be affected. On 12/18/2024, the Regional Director of Clinical Reimbursement and the Vice President Of Clinical Reimbursement completed an audit of current residents care plans to ensure the care plans were updated and reflected Psychotropic, indwelling catheter, and Diabetic Medications, and current ADL assistance. This audit was completed on 12/19/2024. Corrections were made as indicated. 3)On 12/18/2024 the Regional Director	

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F 656	Continued From page 56 pressure is less than 110. 11/15/2024 - Apixaban tablet 5 mg (medication used to keep blood thin), give 0.5 tablet two times a day for A-fib. Review of November 2024 medication administration records indicated Resident #9 had received all ordered medication. A review of the quarterly Minimum Data Set (MDS) assessment dated 8/28/2024 indicated Resident #9 had severe cognitive impairment, was dependent upon staff for her activities of daily living (ADLs), and had a diagnosis of DM. The MDS assessment showed Resident #9 received insulin, antianxiety, antidepressant, anticoagulant, and diuretic medications during the assessment lookback period. An interview completed on 11/21/2024 at 10:55 AM with MDS Coordinator #2 revealed care plans should have been in place for Resident #9's medications, including risk for side effects and the risk for complications related to a diagnosis of DM. MDS Coordinator #2 reported he was not sure why he did not put care plans in place other than he forgot due to half of the care plans being in the computer system and half of them still being on paper. On 11/21/2024 at 11:40 AM an interview was conducted with the Regional MDS Coordinator. During the interview the Regional MDS Coordinator explained when the company changed ownership, they had to print out all existing care plans that were now kept in the MDS office. She also said the paper copy care plans were accessible to all staff so they could	F 656	of Clinical Reimbursement re-educated the MDS Coordinators on policy and procedures of Developing and Implementing a Comprehensive Care Plan. This re-education was completed on 12/18/2024. This education will be added to the facility orientation program for all newly hired MDS Coordinators. 4)The Regional Director of Clinical Reimbursement will randomly audit 10care plans weekly for 12 weeks to ensure Comprehensive Care Plans have been initiated for residents receiving Psychotropic and Diabetic Medications, and current ADL assistance is reflected. The Regional Director of Clinical Reimbursement or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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see the information. The Regional MDS Coordinator further explained that the care plans were supposed to be entered into the computer system, but there was no full-time MDS Coordinator in the facility and there were difficulties getting that done. She reported the care plans should have been updated to reflect the residents' current status.

A review of the paper copies of care plans for Resident #9 that were stored in the locked MDS office failed to show any care plans for risk for complications related to a diagnosis of DM, use of insulin, psychotropic, anticoagulant, or diuretic medications.

An interview was completed on 11/22/2024 at 10:03 AM with the Director of Nursing (DON). During the interview the DON revealed her expectations were that all medications such as antianxiety, antidepressant, anticoagulants, hypnotic, and diuretic medication be care planned. The DON explained the diagnosis of DM needed to be care planned as well due to the risk for complications.

2. Resident #199 was readmitted to the facility on 11/4/2024. His diagnoses included urinary retention.

Review of Physician orders showed the following orders in place:

11/4/2024 - Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate side of securement daily and as needed.

11/4/2024 - Monitor for potential complications of

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indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter.

11/4/2024 - Provide catheter cleansing and perineal hygiene daily and as needed if soiled.

11/11/2024 - Flush suprapubic catheter with 60 milliliters (ml) of normal saline every shift

11/13/2024 - Treatment: Clean wound on left proximal thigh with dermal wound cleaner then apply calcium alginate to wound bed and cover with gauze island dressing.

Review of the most recent wound note dated 11/18/24 revealed the following information:

Stage 3 Pressure Ulcer to left proximal thigh older than 88 days, showing improvement.

Stage 3 Pressure ulcer to left buttock older than 39 days, showing improvement.

Non-pressure ulcer wound to the left distal thigh less than one day old.

A review of Resident #199's quarterly Minimum Data Set (MDS) dated 11/10/2024 revealed Resident #69 had no cognitive issues, was dependent upon staff for toilet hygiene, had an indwelling (suprapubic) catheter, and had 3 stage 3 pressure ulcers present with pressure ulcer care marked.

Review of Resident #199's care plan last reviewed on 11/15/2024 revealed no care plans related to a suprapubic catheter or current

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pressure ulcers.

An observation and interview were completed with Resident #199 at 11/18/2024 at 1:31 PM. During the interview Resident #199 reported he had a catheter in place, and it had been there for about 6 months due to not being able to feel the need to urinate. During the interview an indwelling catheter was observed draining light yellow liquid.

A telephone interview was completed on 11/21/2024 at 11:40 AM with the Regional MDS Coordinator. During the interview she reported there should have been a care plan in place for Resident #199's indwelling catheter and pressure ulcers. The Reginal MDS Coordinator further explained there was not a full-time MDS Coordinator in the facility and there had been issues making sure all the care plans had been updated. She also reported that when the facility changed ownership in June of 2024 all of the care plans were printed off and stored in the MDS office that was accessible to all staff, but they should be updated in the computer system.

A review of the paper care plan for Resident #199 dated 6/17/2024 that was stored in the locked MDS office failed to show care plans in place for an indwelling catheter or pressure ulcers.

An interview was completed on 11/22/2024 at 10:03 AM with the Director of Nursing (DON). During the interview the DON stated she expected to see any special equipment such as indwelling catheters and skin issues to be on the care plan.

During an interview completed with the former Administrator due to the new Administrator being

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in the facility for less than a week, on 11/22/2024 at 11:03 AM he stated the care plans should reflect the current status of the resident including medications.

3. Resident #1 was admitted to the facility on 11/11/2014 with diagnoses of major depressive disorder and diabetes mellitus.

A review of Resident #1's medical record revealed a physician order dated 7/15/24 for aripiprazole (an antipsychotic medication) 15 milligrams (mg) once daily for bipolar disorder, a physician order dated 7/15/24 for zolpidem tartrate (a sedative) 5mg once at bedtime for insomnia, a physician order dated 7/15/24 for dulaglutide injection (a medication to lower blood sugar) inject 0.5 milliliters (ml) subcutaneously one time a day every Tuesday for diabetes mellitus, and a physician's order dated 8/1/24 for glipizide (a medication to lower blood sugar) 1.5 tablets one time a day for diabetes mellitus.

A review of Resident #1's October and November 2024 Medication Administration Record (MAR) revealed she had been receiving the psychotropic medication, and diabetes mellitus medications as ordered.

A review of the most recent quarterly Minimum Data Set (MDS) dated 10/25/24 showed Resident #1 received antipsychotic and hypnotic medications. The MDS further revealed she required substantial assistance with dressing, bathing, and bed mobility and was dependent on staff for toileting and transferring.

Resident #1's care plan last reviewed on 9/20/2024 revealed there was no care plan in

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F 656	Continued From page 61 place for psychotropic medication use, assistance with ADL, and diabetes mellitus therapy. An interview was completed with the MDS Consultant on 11/21/24 at 11:54 AM. It revealed the care plan should be updated after the MDS assessment is completed. She stated the updated care plans were in a physical binder in the MDS office, not in the Electronic Medical Record (EMR), as the facility switched EMR systems recently. The MDS Consultant revealed assistance with ADL, diabetes mellitus therapy, and psychotropic should be itemized in the care plan for Resident #1. An interview with the DON on 11/22/24 at 10:07 AM revealed assistance with ADL, diabetes mellitus therapy, and psychotropic medication should be listed in the care plan for Resident #1 to reflect her needs. An interview with the Administrator on 11/27/24 at 11:20 AM revealed he expected a care plan that detailed assistance with ADL's, diabetes mellitus therapy, and psychotropic medication use would be in place for Resident #1.	F 656		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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.	F 684		11/29/24

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F 684	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, facility staff, Nurse Practitioner (NP), Medical Director (MD), and Physician Assistant (PA) interviews, the facility staff failed to recognize the seriousness of a significant change in condition, complete comprehensive and ongoing assessments, and identify the need for urgent medical attention. On 09/14/24 at 9:05 AM Nurse #3 heard a loud hit or thud coming from across the unit and then observed Resident #49 rolling out of his room in his wheelchair and witnessed Resident #79 swinging his arm with a fist and hit Resident #49 on the back of the head. Resident #49 was noted to slump over in his wheelchair and have a loss of consciousness for a few seconds before opening his eyes and requesting to go outside and smoke. Resident #49 had a history of a traumatic brain injury and immediately after being hit in the head by Resident #79 he was noted to have a change of condition as evidenced by a change in level of assistance needed for transfer and bed mobility changed, confusion and inability to self-propel in his wheelchair. There was a lack of effective communication between staff after Resident #49 was transferred to a different hall around 10:00 AM and no care or assessments were provided by a nurse until 3:00 PM. There were no documented comprehensive assessments or neurological checks located in the medical record after the initial nursing note after the incident. Later in the day Resident #49 slid out of wheelchair to the floor and was assessed with worsening generalized weakness and concern for a concussion. Emergency Medical Services (EMS) was dispatched on 9/14/24 at 6:31 PM and Resident #49 was taken to the hospital for	F 684	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F684 1) On 09/14/2024 at 9:05 AM, Nurse #1 heard a loud hit or thud coming from across the unit. Nurse #1 then noted Resident #49's wheelchair rolling out from his room with him in the wheelchair and witnessed his roommate swing his arm with a fist and hit Resident #49 in the back of the head. The facility failed to provide ongoing monitoring when the staff failed to communicate amongst themselves that after the incident and Resident #49 had a room change and a change in nursing staff. Based on staff interview, Resident #49 had a significant change in condition as evidenced slumping in chair, changes in transfer mobility and bed mobility	

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F 684	Continued From page 63 evaluation. A Computed Tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms. Resident #49 returned to the hospital on 9/17/24 for evaluation of acute chronic left-sided weakness, lightheadedness, blurred vision and headaches. Resident #49 was admitted for neuroimaging (brain scanning). The Neurologist felt the findings could represent post concussive changes and Resident #49 was discharged back to the facility on 09/20/24 with orders to follow up with neurology outpatient. At the time of the survey, Resident #49 reported he felt his condition had changed since the incident and noted he was now confined to a specialized chair and was dependent upon staff for all activities of daily living and required the use of mechanical lift for transfers. In addtion, the facility failed to assess a resident for injury before moving them when Driver #1 was transporting Resident #55 in the facility van and he fell backwards in his wheelchair and hit his head on the van floor resulting in severe head pain. Driver #1 lifted Resident #55 back into an upright position and drove him back to the facility without being assessed by a medical professional. Driver #1 had not been trained on how to respond or what to do in emergency situation or accident. Resident #55 was assessed by Nurse #1 and noted to have a swollen area with abrasions to the back of his head. Resident #55 was transferred to the hospital for further evaluation and was diagnosed with a closed head injury, scalp abrasion and strained neck muscles. This deficient practice occurred for 2 of 3 sampled residents reviewed for quality of care (Resident #49 and Resident #55).	F 684	requiring additional staff to help resident to transfer, turn and reposition and more assistance with activities of daily living and altered mental status. The on-call Nurse Practitioner was notified at 7:00 PM after Resident #49 was noted to be lying on the floor after sliding out of his wheelchair. He was noted to have Altered Mental Status (AMS) and was sent to the hospital for further evaluation due to a concern for a concussion. On 11/21/2024 & 11/22/2024 all current residents were reviewed by a licensed nurse with vital signs obtained to determine if they are experiencing a current change in condition to include head trauma/injury which would require them to be sent out to the hospital for further evaluation and treatment. Residents identified to have a change in condition, the medical provider is notified, and neuro-checks and/or vital signs were done after the change was noted. Each resident's licensed nursing review is noted in the electronic health record. On 11/22/2024, the DON/RN Nurse Manager reviewed the 24-report for 11/21/2024 and 11/22/2024 to ensure no current changes in condition requiring notification to the Medical Provider for transfer to a higher level of care for further evaluation and treatment.	

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F 684	Continued From page 64 Immediate Jeopardy began on 09/14/24 when Resident #49 who had a history of a traumatic brain injury was hit in the head and facility staff failed to identify the seriousness of the change in condition and complete comprehensive assessments to determine if a higher level of care was needed. Immediate jeopardy began for Resident #55 on 11/15/24 when he was lifted back into an upright position by Driver #1 before he was assessed for injury by a medical professional. The immediate jeopardy was removed for Resident #55 on 11/22/24 and for Resident #49 on 11/23/24 when the facility implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: 1. Resident #49 was a 38-year-old admitted to the facility on 10/18/2023 with a diagnosis of traumatic brain injury (TBI). A review of Resident #49's quarterly Minimum Data Set assessment dated 07/26/24 revealed he was cognitively intact. Resident #49 was coded as independent for eating and putting on/ taking off footwear. He required set up or clean up assistance for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and personal hygiene. Resident #49 required supervision assistance for chair to bed transfers, toileting transfers, tub/shower transfers and lying to sitting on the side of the	F 684	On 11/21/2024 and 11/22/24, the Regional Clinical Director re-educated the Director of Nursing and the Nurse Managers regarding ensuring a thorough report between nursing staff at any time when residents move rooms to ensure continuity of care and to establish a baseline in the event that there is a change in condition. Education also included obtaining vital signs and initiating and completing neurological checks when a resident experiences head trauma or if there is an unwitnessed event such as a fall for which the resident could have experienced head trauma. Shift-to-shift report is verbal and/or written and may include but not be limited acute changes in condition, infections, falls, blood sugars that are critical, held medications, PRN medications that were given, exacerbated behaviors, refusals of medications or care, neurological checks that are in place, safety checks that are in place. Education also included that with significant changes in condition such as significant changes in consciousness, mental status, mobility, strength and/or vital signs, there should be immediate notification the provider to send the resident out to a higher level of care for further evaluation and treatment, and the notification and the assessment is to be documented On 11/22/2024 the Director of Nursing and the	

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F 684	Continued From page 65 bed. The resident was noted to be independent for rolling left and right while in bed. Resident #49 was continent of bowel and bladder during the assessment period and was documented to have no behaviors. Resident #79 was a 40-year-old admitted to the facility on 06/15/23 with a diagnosis of TBI. A review of Resident #79's quarterly Minimum Data Set assessment dated 09/07/24 revealed he was cognitively intact. Resident #79 was coded as independent for all activities of daily living (ADL) including eating, toileting, oral hygiene, shower/bathe self, upper body dressing, lower body dressing and all transfers. He was coded as using a cane to ambulate during the assessment period. Resident #79 was documented to have no behaviors. A review of the facility's investigation report initiated on 09/14/24 at 9:05 AM by the Administrator revealed Resident #49 was hit on the back of his neck/head by his roommate. After the nurse assessed Resident #49, he was noted with no injuries and the residents were immediately separated by moving Resident #49 to another room. Staff were briefed on the incident and monitored the residents every 15 minutes to avoid further incidents. Resident #49's roommate had stated he hit the resident because he was trying to exit the room and Resident #49 was blocking the doorway with his wheelchair. An Occupation Therapy (OT) discharge summary dated 09/06/24 revealed Resident #49 received therapy services initiated on 07/18/24 through 09/06/24. Skilled interventions provided included instructing and training Resident #49 in proper	F 684	Nurse Managers re-educated the Licensed Nurses to include agency staff regarding ensuring a thorough report between nursing staff to include the Certified Nurse Aides at any time including at beginning and end of shift and when residents move rooms to ensure continuity of care and to establish a baseline in the event that there is a change in condition. Nursing staff were re-educated on identifying a change in condition through observations, resident interactions and vital sign changes. Additionally, re-education to Licensed Nurses also include obtaining vital signs and initiating and completing neurological checks when a resident experiences head trauma or if there is an unwitnessed event such as a fall for which the resident could have experienced head trauma. Neuro checks are completed on a paper document. Included in a neurological check is the resident’s level of consciousness, pupils' equal round and reactive to light and accommodation, hand grasps, motor functions, pain response, vital signs. Neurological checks are every 15 minutes x 4, then every 30 minutes x 4, then every hour x 4 and then every 4 hours x 4 and then every shift for a total of 72 hours from the time of initiation. Licensed Nurses complete the neurological check sheets, and they are given to the DON or Nurse Manager upon completion. Education also included documenting assessments and completing neurological	

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F 684	Continued From page 66 body mechanics, positioning/ pressure relieving techniques, safe transfer techniques and use of adaptive equipment in order to improve independence and engagement of ADL and self-care task. At the time of therapy discharge Resident #49 was set up assistance for eating, partial/moderate assistance for toileting hygiene, supervision for toileting transfers and set up assistance for bathing. The resident's self-care function score on a scale of 0-12 (12 being the highest function of independence) was a 10. A nursing note written by Nurse #3 dated 09/14/24 at 10:11 AM revealed she heard hitting noises and turned around to observe Resident #49 get hit in the head by his roommate. The note revealed the residents were separated and assessed for injuries. Resident #49's vital signs were the following: blood pressure 138/66, pulse 72, temperature 97.9, respirations 20, oxygen saturation level 96% on room air. The resident was noted with no signs of acute distress at the time of the incident and no complaints of pain. Redness was noted to the back of the resident's neck. The residents Responsible Party, Director of Nursing and on call Nurse Practitioner were notified. New orders were obtained for a psychological evaluation of Resident #79 and every 15-minute monitoring for a duration of 24 hours. A review of Resident #49's medical record revealed the only documented vital signs were included on Nurse #3's progress note on 9/14/24 at 10:11 AM. Further review of the medical record revealed no neurological or resident assessments were documented. On 11/19/24 at 11:38 AM an interview was	F 684	checks and upon completion they will be given to the Director of Nursing or Nurse Manager. Education completed via phone and in person. On 11/22/24, Nurse Aides were educated by the Licensed Nurse Manager that they are to report changes in resident condition to the Licensed Nurse. These changes may include but are not limited to changes in toileting, transfers, eating, mobility, skin changes, mental status changes, behaviors, refusals of care. Nurse aides are to report changes noted with residents immediately to the Licensed Nurse. Education completed via phone and in person. This education was completed on 11/22/2024. This education for the nursing staff will be the responsibility of the DON/Licensed Nurse Managers for current staff and will continue during the orientation period for any newly hired staff ongoing. The Director of Nursing/Designee will audit the 24-hour, including SBAR assessments 5 times a week for 12 weeks to ensure changes in condition are reported to the Physician or Nurse Practitioner timely. The Director of Nursing or designee will	

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F 684	Continued From page 67 conducted with Nurse #3. Nurse #3 stated on 09/14/24 around 9:00 AM she heard a loud hit or thud coming from across the unit. She then saw Resident #49 rolling out from his room in his wheelchair and witnessed (Resident #79) who was cognitively intact, swinging his arm with a fist and hit Resident #49 at the back of the head making a second thud sound as his fist hit the back of Resident #49's head. Resident #49 immediately slumped over in his wheelchair and regained consciousness within a couple of seconds after she got to him to assess his condition. She stated she saw redness at the back of Resident #49's head and neck area. When Resident #49 came to he asked to go outside to smoke so Nurse Aide (NA) #2 took him to the smoking area. Nurse #3 indicated she had obtained initial vital signs on the resident which were within normal range, assessed him and the Unit Manager notified the Nurse Practitioner of what had occurred. Nurse #3 explained when Resident #49 was moved from her hall around 10:00 AM, she no longer was his nurse and did not see him again that day. The interview revealed she had initiated an action rounding log which documented where the resident was in the facility every 15 minutes. Upon review of the action rounding sheet Nurse #3 confirmed her initials were on the sheet documenting on the resident from 9:00 AM to 3:00 PM, however she did not recall putting her initials on the paper nor had she checked on the resident every 15 minutes during the shift. Nurse #3 stated Nurse #4 took over Resident #49's care when he moved to his new room around 10:00 AM. Nurse #3 gave Nurse #4 a short description of what had occurred between the two residents and went back to her unit. The interview revealed the facility would typically complete neurological	F 684	be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits. 2) On 11/15/2024 at approximately 11:20AM Resident #55 had a fall in the facility van during return from dialysis when the wheelchair tipped backwards, and Resident #55 struck his head on the van floor resulting in an injury to the back of his head and pain. The facility Transportation Driver immediately pulled over to the next parking lot, flagged down someone in the parking lot and they lifted Resident #55 back into an upright position. Resident #55 was not assessed by a medical provider before being moved from the floor of the van. The Facility Transportation Driver called the Unit Manager at the facility on the way back. On 11/15/2024 at approximately 11:30 AM Resident #55 returned to the facility. The nurse immediately assessed Resident #55 including Head-to-Toe assessment, Range of Motion all extremities, pupils equal, round and reactive to light and accommodation and completed a pain assessment. Resident #55 was alert and oriented x 4 per baseline.	

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F 684	Continued From page 68 assessments after a head injury, however since Nurse #4 assumed responsibility for the resident it would have been up to her to complete the assessments and monitoring. Nurse #3 stated she did not initiate neuro checks for the resident. On 11/21/24 at 12:32 PM an interview was conducted with Scheduler #1. She stated she was working as the Manager on Duty on 09/14/24. Scheduler #1 stated her office door was open and she overheard a nurse screaming for help. When she went out into the hall, she saw Nurse #3 and went to her. Scheduler #1 stated Resident #49 sitting in his wheelchair slumped over and was unconscious for approximately a minute. Nurse #3 explained to her that he had just been hit in the back of the head by Resident #79. When he initially woke up after being hit and "came to", his abilities were not the same, he was using his hands but nothing else like he had before. She stated he was no longer able to self-propel himself in the hallway as he had done that morning or self-transfer to bed. After separating the residents, she stated she notified the Unit Manager #1 via the facility paging system and Nurse #3 called the Director of Nursing. Scheduler #1 stated Resident #49 was taken to the smoking area by NA#2 because he stated he wanted to go smoke. She stated Resident #49 immediately seemed spaced out by responding slowly when spoken to and not thinking clearly. The interview revealed Resident #49 started trying to go in the wrong direction and had to be redirected by staff. When they took him to his new room, it took Scheduler #1, NA #2 and Nurse #3 to all assist him into the bed. Scheduler #1 told Nurse #3 she would need to complete neurological assessments. She stated they were so concerned with Resident #49's condition they	F 684	Resident #55 sustained a hematoma to the back of his head with a small abrasion noted to the area. First aid was provided by the nurse to the area on resident's head, and medications administered per schedule and pain medication administered. The resident reported to the nurse that when the van moved, he fell backwards and hit his head. The nurse called 9-1-1 and sent Resident #55 out via EMS at approximately 12:01 PM. The Director of Nursing and the Nurse Practitioner were notified along with Resident #55's Responsible Party. On 11/15/2024 the facility Transportation Driver was suspended pending investigation, and an investigation was immediately initiated by the Director of Nursing, which included interviewing the facility Transportation Driver. As per the facility Transportation Driver's interview and the visualization of return demonstration by the facility Transportation Driver, Resident #55 was strapped into the van with all 4 wheelchair restraints and the seatbelt. The wheelchair locks were also locked on both wheels. The facility Transportation Driver could not recall if he had been trained not to move the resident, notify the facility or call 911. The facility Transportation Driver stated he moved Resident #55 from the van floor out of instinct, as he just wanted to make sure Resident #55 was comfortable. On 11/15/2024 the Director of Nursing scheduled all resident transport with	

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F 684	Continued From page 69 had placed a fall mat under his bed because they felt like he may have a fall from the bed due to his state of immobility. Scheduler #1 stated she did not voice her concerns to anyone because she thought Nurse #3 and Nurse #4 were communicating the residents' changes to the Medical Provider. The interview revealed Resident #49 had experienced a couple of falls following the incident and was sent back to the hospital on 09/17/24 for a reevaluation due to complaints of a headache. On 11/21/24 at 9:06 AM an interview was conducted with Unit Manager (UM) #1. During the interview she stated on 09/14/24 around 9:00 AM she was paged on the overhead call system to come to Resident #49s room. Upon arrival Nurse #3 told her Resident #49 had been hit on the back of his head by Resident #79. She stated she looked at the resident and he was able to respond to her. She had them remove Resident #49 from the room and contacted the Director of Nursing (DON) who stated she needed to notify the resident's family and the provider on call. She stated the provider on call (NP #3) asked her how the resident was doing, and she stated it was her first time laying eyes on him, and he seemed okay. NP #3 instructed the facility to notify them of any change of condition. UM #1 recalled they immediately moved Resident #49 to a room in another hall around 10:00 AM. She stated it was her understanding after talking with Nurse #3 that Nurse #4 was going to assume care of the resident when he moved to the new room. Unit Manager #1 stated she was rounding later in the day and saw Resident #49's call light on, she stated he was trying to transfer himself from the wheelchair to the toilet which the NA said he was normally able to do. She stated she had to get	F 684	contracted transportation company until further notice. On 11/15/2024, at approximately 5:49 PM, Resident #55 returned from the Emergency Department status post Computed Tomography Scan which was negative. No orders were received from the Emergency Room. Upon return to the facility, neurological checks were initiated. Head to toe skin assessment and pain assessment completed. Resident #55 complained of headache, and Hydrocodone/APAP 5/325mg was administered by the nurse as ordered. Resident #55 was alert and oriented per baseline. Upon return to the facility the Nurse Practitioner was notified, and orders were given to apply ice to the back of Resident #55's head and an additional order to cleanse the area and apply a dry dressing to his head daily and as needed. All residents have the potential to be affected. On 11/15/2024 Head-to-toe skin assessments were completed for all residents on the transport schedule for the facility van from 11/13/2024-11/15/2024 as a precaution since the Facility Transportation Driver had only started driving the van on 11/13/24. No concerns were identified. On 11/15/2024, at approximately 12:20PM the Regional Clinical Director	

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F 684	Continued From page 70 two other staff members to assist due to his weakness. She stated Resident #49 was so weak she asked the Resident to hold off on all transfers for the rest of the day because he was now a full assist for transfers. She contacted Nurse Practitioner (NP) #2 who told her she would be in the building to round shortly. UM #1 explained she spoke with the DON after she called NP #2 to let her know NP #2 was going to evaluate the resident. UM #1 revealed the DON told her to activate Emergency Medical Services (EMS) because she did not feel comfortable with his condition. EMS arrived at the same time as NP #2 came onsite around 3:00 PM. NP #2 completed an assessment of Resident #49 and stated to her (UM #1) to turn EMS away, that the resident had no reason to go out for an evaluation. UM #1 indicated she disagreed with the decision, however, went along with it and sent a message to the DON letting her know EMS was turned away. UM #1 indicated shortly after she had them turn EMS away the resident was in his wheelchair he slid out of his wheelchair onto his bottom. She stated the staff had moved Resident #49 to his wheelchair because his legs kept dangling off of the bed and she was afraid he was going to fall. Unit Manager #1 indicated after Resident #49 slid out of his wheelchair she called NP #2 and notified her Resident #49 was going to be sent to the hospital for an evaluation. On 11/22/24 at 9:38 AM an interview was conducted with NP #3. During the interview she stated she was the on-call provider assigned for the facility on 09/14/24 (Saturday). NP #3 stated she did recall being notified of an altercation with Resident #49 around 10:00 AM but did not recall the details of the phone conversation of what she was told by the nurse. She stated typically if she	F 684	provided re-education by phone to the Administrator and Director of Nursing. This education included emergency protocols, including not moving the resident if an accident/event occurs on the facility or contracted vehicle, immediate notification to the facility and/or Administrator and the Director of Nursing, calling 9-1-1 and keeping the resident safe until Emergency Medical Services (EMS) arrives. On 11/15/2024, at approximately 1:00 PM, Immediate re-education provided by the Director of Nursing to the facility Transportation Driver per facility written policy. This re-education included emergency protocols, including not moving the resident if an accident/event occurs on the facility or contracted vehicle, immediate notification to the facility and/or Administrator and the Director of Nursing, calling 9-1-1 and keeping the resident safe until Emergency Management Services (EMS) arrives. On 11/15/2024, the Director of Nursing contacted the only contract transportation company utilized by the facility. The 2 van drivers and the owner were educated via phone on emergency protocols, including not moving the resident if an accident/event occurs on contracted vehicle, immediate notification to the facility and/or Administrator and the Director of Nursing, calling 9-1-1 and keeping the resident safe until Emergency Management Services (EMS) arrives. The van drivers and the owner	

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F 684	Continued From page 71 was notified a resident was struck in the head she would recommend sending the resident to the hospital for an evaluation. She stated she was not contacted by the facility for Resident #49 anymore that day because they had an in-house NP (NP #2) that was rounding on the residents. The interview revealed she did not have any notes from the day as to what orders she gave the facility. On 11/19/24 at 12:52 PM an interview was conducted with Nurse Aide (NA) #2. NA #2 stated she was responsible for Resident #49 on 09/14/24 during first shift (7:00 AM to 3:00 PM). She stated she did not witness the incident but was notified of what had happened by Nurse #3. NA #2 recalled she was told by Nurse #3 to take Resident #49 outside to smoke and to move Resident #49's belongings out of his room into a new room on another unit. NA #2 indicated she moved Resident #49's belongings and assisted him from the smoking area to his new room around 10:00 AM and assisted him into the bed which was different from that morning. Earlier in morning, he was able to transfer himself. The interview revealed when she went to the smoking area to get Resident #49, he did not have a cigarette and was just sitting outside. NA #2 stated she had discussed Resident #49's change of condition with both Nurse #3 and Nurse #4 as soon as she assisted Resident #39 into his bed in the new room that morning. NA #2 stated she immediately noticed a difference in the way Resident #49 was responding and moving. NA #2 stated Resident #49 could not assist her at all for bed mobility and had to remain in bed for the rest of her shift. NA #2 explained she decided to continue to provide care to the resident despite him being on another unit due to staffing	F 684	voiced understanding. A written copy of the policy was provided to the contracted transportation company. Per the contracted transportation company owner, this education will be added to the company orientation process for any new hires. On 11/15/2024 the Director of Nursing began education for all staff, including administration, housekeeping, laundry, dietary, maintenance, department managers and nursing including agency staff on the facility protocol if receive a call from the facility Transportation Driver or contracted transportation driver/company of an accident/event occurrence on the van. This education included immediately instructing the driver not to move the resident, ensure resident(s) are safe at all times, calling 9-1-1 and calling the facility Administrator and the Director of Nursing. This education was provided in person and via phone for the staff who were not working. This education was completed for all staff on 11/16/2024. This education will be added to the facility orientation program, including agency staff. The Director of Nursing/Designee will interview Facility Transportation Driver weekly for 12 weeks on proper emergency protocol, including what to do if an	

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F 684	Continued From page 72 concerns. NA #2 indicated Resident #49 had gone from being able to transfer himself that morning to being unable to roll from left to right in the bed following the incident. For the remainder of the shift Resident #49 was provided with incontinent care in bed, which was a change of condition. NA #2 also noted Resident #49 seemed slow to respond when she spoke to him. NA #2 stated she was not given instructions to obtain vital signs on Resident #49 during first shift and gave report to NA #1 at 3:00 PM. On 11/19/24 at 2:00 PM an interview was conducted with NA #1. During the interview she stated she came on shift at 3:00 PM and received report from NA #2. NA #1 recalled she and the Unit Manager #1 assisted Resident #49 to his wheelchair because his legs were dangling off of the bed around 4:00 PM. NA #1 noted Resident #49 to be disoriented, leaning back in his wheelchair, sliding out of his wheelchair and overall, not looking like he typically did, sitting up, self-propelling himself in a regular wheelchair in the hallway. NA #1 indicated Resident #49 usually transferred himself to the bathroom but that shift he was incontinent, and she was changing Resident #49's brief while he was in bed which was a change. NA #1 remembered having to assist him back up in his wheelchair during that evening and he eventually slid completely out of his wheelchair into the floor in the hallway around 6:30 to 7:00 PM. The interview revealed Resident #49 was sent to the hospital for an evaluation. NA #1 stated she did not recall obtaining vital signs for Resident #49 nor was she asked about his condition. The interview revealed she had notified Nurse #4 during her shift around 4:00 PM that Resident #49 seemed different from his baseline state.	F 684	accident/event were to occur during transportation. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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On 11/19/24 at 2:49 PM an interview was conducted with Nurse #4. She stated she was in the building on 09/14/24 during the first shift (7:00 AM to 3:00 PM) and second shift (3:00 PM to 11:00 PM). The interview revealed Resident #49 was moved to her hall following an altercation with Resident #79 during which Resident #79 hit Resident #49 on the back of his head. She stated she assumed Resident #49's care for second shift at 3:00 PM. The interview revealed Resident #49 was noted to be in bed, which was not usual because he was typically up and out in the facility in the hallway during the day. Nurse #4 indicated she did not report the change of condition to the Medical Provider. Nurse #4 stated the NA #1 and NA #2 were telling her he was experiencing a significant change of condition from his normal baseline by being in bed, a decrease in mobility, decreased alertness and incontinence throughout the day. Nurse #4 explained Resident #49 was gotten up to his wheelchair for the supper meal and he kept sliding out of the wheelchair and Nurse #4 had to obtain other staff members to assist her to pull him up in his chair. Nurse #4 indicated around 6:30 PM Resident #49 was noted to fall out of his wheelchair onto the floor in the hallway. Resident #49 was immediately sent to the hospital for an evaluation based on the nurse aides telling her of the resident's drastic change of condition and the fall. Nurse #4 stated prior to the incident Resident #49 was independent in his wheelchair, however when he left to go to the hospital, he was dependent upon staff for transfers using a mechanical lift. Nurse #4 recalled she had completed an action rounding sheet starting at 3:00 PM on Resident #49 which meant every 15 minutes the staff were documenting where the resident was in the

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facility. She stated they did not have to complete vital signs on a schedule or neurological assessments on the resident because she thought Nurse #3 had completed them. Nurse #4 thought the first shift nurse had taken care of the neurological assessments and the resident until 3:00 PM. She explained that Nurse #3 had initialed the action rounding sheet during the first shift. Nurse #4 stated she did not receive report from Nurse #3, it was just known around the facility what had happened to Resident #49 and why he had to change rooms. The interview revealed Nurse #4 did not know she was supposed to assume the residents care when he initially moved to the new room around 10:00 AM because typically if a resident moved the nurse initially responsible would continue to care for them throughout the shift until the next shift arrived. Nurse #4 further stated after the resident came back from the hospital, she had taken care of him during second shift on 09/15/24 when he experienced a fall out of bed. The resident stated he was trying to fix himself in the bed and had just slipped down onto the fall mat located to the side of his bed. She stated he did not report hitting his head and was placed back in bed. The on-call physician was notified on 09/15/24 at 11:40 PM of the fall and stated to monitor the resident. Nurse #4 confirmed she did not assess or provide any care to Resident #49 until 3:00 PM.

A SBAR (Situation, Background, Assessment and Recommendation) Summary dated 09/14/24 at 3:35 PM written by Unit Manager #1 revealed Resident #49 had experienced a change of condition after a physical altercation with another resident. The chief complaint was listed as Resident #49 had become increasingly weak on

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the left side after a physical altercation at the hands of another resident. The on- call provider was notified of the residents' condition and instructions were placed to activate Emergency Medical Services (EMS) for an evaluation at the Emergency Department.

Review of the Emergency Medical Services dispatch log for the facility on 09/14/24 revealed they were initially notified to respond for Resident #49 at 3:33 PM due to a physical decline after a physical altercation. EMS was en route to the facility at 3:47 PM and cancelled at 4:04 PM.

A Nurse Practitioner note written by NP #2 on 09/15/24 as late entry for 09/14/24 revealed she was asked to see Resident #49 for altered mental status after an altercation in which the resident ended up on the floor knocked out cold, he did not hit his head and regained consciousness right away but now seen with altered mental status. At the time of the assessment, although he was able to follow simple commands, he was noted to have worsening generalized weakness "drop in extremity" sitting in the chair. She was noted to be concerned for a concussion and escalated the resident to the emergency room for an evaluation and management.

On 11/22/24 at 9:14 AM an interview was conducted with Nurse Practitioner #2. She stated she was an in-house provider that rounded in the facility on the weekends. She stated she remembered evaluating Resident #49 while he was sitting in a chair, but NP #3 was originally notified that morning about an altercation. NP #2 stated staff did tell her the resident had been hit in the head by his roommate and had experienced altered mental status. However, she

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did not witness the incident and therefore it was only hearsay. NP #2 stated she only recalled sending the resident out to the hospital following a fall around 6:30 PM and did not recall telling anyone to stop EMS from coming at 3:00 PM.

A late entry incident report dated 09/14/24 at 11:02 PM written by Nurse #4 revealed Resident #49 had experienced a fall and was found in the hallway sitting on his bottom around 6:30 PM. Resident #49 stated he had slid off his wheelchair. No injuries were observed however the resident was sent to the hospital due to recent change in cognition.

Review of the Emergency Medical Services (EMS) dispatch log for the facility on 09/14/24 revealed they were notified to respond for Resident #49 at 6:31 PM due to a fall in which the resident slipped from his chair to the floor. EMS arrived at the facility and transported Resident #49 to the hospital.

EMS records dated 09/14/24 revealed they were dispatched to the facility with a chief complaint of increased weakness and a fall after an assault earlier in the morning. The resident had a history of TBI and wanted to be evaluated. Resident #49 stated he was hit in the head by Resident #79 earlier in the morning around 9:00 AM. He stated Resident #79 used his fist to hit him in the head and denied loss of consciousness. Staff, however, did say the resident lost consciousness. The resident was cleared initially by his facility physician to stay at the facility and not be transported to the hospital. Around 6:30 PM Resident #49 was sitting in his wheelchair, when he tried to reposition himself, he had increased

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weakness that caused him to slide down the chair onto the floor. The resident was noted to be on the floor when the medic arrived. Resident #49 was mechanically lifted into the medic's stretcher. EMS documented the resident's vital signs at 6:52 PM to include the following: blood pressure 120/76, pulse 70 beats per minute (bpm), respirations 16, oxygen saturation level 94% (normal >92%). Resident #46 was noted to be oriented to person, place and time. The resident stated to EMS he felt safe at the facility, however, would like a new roommate. The note read, "Patient is requesting we transport him to the hospital for further evaluation."

Hospital records dated 09/14/24 revealed Resident #49 was evaluated on this date after sliding out of his wheelchair around 6:30 PM. Per the Medic the resident was also punched in the head by his roommate earlier in the morning around 9:30 AM but cleared by the facility. The residents' diagnoses included fall, closed head injury and generalized weakness. A Computed Tomography (CT) scan was completed which resulted in no acute findings. Resident #49 was discharged back to the nursing facility on 9/15/24 with strict precautions to return with any new or worsening symptoms.

A nursing progress note dated 09/15/24 at 6:55 AM revealed Resident #49 had returned to the facility from the hospital by EMS transport. Resident #49 was noted to be in no acute distress or discomfort.

An incident report dated 09/15/24 at 11:38 PM written by Nurse #4 revealed Resident #49 had an unwitnessed fall and was found on the floor of his room. The resident stated to the nurse that he

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was trying to fix himself in the bed. No injuries were observed at the time of the incident and the resident denied hitting his head. A Nurse Practitioner on call was notified of the fall and stated to monitor the resident for any changes.

An incident report dated 09/16/24 at 6:15 AM written by Nurse #5 revealed Resident #49 had experienced an unwitnessed fall and was observed laying on his back on the floor of his room. His legs and feet were noted to be tangled in his sheets while he was on the floor. Resident #49 denied hitting his head, he stated he had slid with the covers landing on his bottom and his back. No open or bruised areas were noted to the residents' body. NP #1 was notified of the fall on 09/16/24 at 7:54AM.

An interview was attempted with Nurse #5 on 11/20/24 at 10:35 AM with no return phone call received to the surveyor.

A Nurse Practitioner note dated 09/16/24 written by NP #1 revealed she was asked to evaluate Resident #49 on this date by the Director of Nursing (DON) due to the resident being sent to the Emergency Department (ED) after he was forcefully hit in the head by his roommate and had experienced a couple of falls since the incident. Resident #49 was noted to have been evaluated for a close head injury while in the hospital. At the time of her assessment the resident was noted to be in a stable condition with no complaints of pain or weakness. During the evaluation he was noted to be in bed resting with no acute distress.

On 11/19/24 at 3:36 PM an interview was conducted with Nurse Practitioner #1. During the

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interview she stated Resident #49 was sent to the hospital on 09/14/24 following a fall in the facility. She stated she was not in the facility or on call the weekend the incident occurred but learned of the altercation the following Monday after returning to the facility. NP #1 stated Resident #49 had experienced two falls after returning back to the facility from the hospital and she was asked to evaluate him on 09/16/24 following the second fall. Resident #49 was in no distress during her evaluation. The interview revealed Resident #49 started experiencing headache, weakness and lightheadedness on 09/17/24 while she was in the building and was sent back to the hospital. He was discharged back to the facility on 09/20/24. NP #1 stated she had written a progress note on 10/21/24 discussing the hospital course and they had conducted a neurological work up while the resident was in the hospital. She stated the hospital notes did discuss the resident could have had post concussive findings meaning it was possible he had experienced a concussion from the incident, but they were unable to determine if it was that or a past misdiagnosis. NP #1 stated Resident #49 is now in a specialized wheelchair that leaned back unlike the chair he was in prior to the incident which was a regular wheelchair. She stated once he came back from the hospital, he was slow to respond with occasional headaches and was not as active as he was prior to the incident. She stated it was possible the effects he has experienced could be from the altercation, but the resident had other conditions that could have contributed to the changes he had experienced.

Hospital records dated 09/17/24 revealed Resident #49 presented to the hospital for evaluation of acute chronic left-sided weakness.

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The resident was reported to have been punched in the head by a roommate 3 days prior. He was originally evaluated in the Emergency Department on 09/14/24 and cleared for discharge. He presented back to the hospital complaining of lightheadedness and felt that his left side was weaker than his baseline from prior brain injury. He was also complaining of blurred vision and headaches. Resident #49 was admitted for neuroimaging. The exam showed a decreased edema signal within the brainstem (indicating potential damage or abnormality within the brainstem region) since the prior exam. Neurology was consulted with orders to follow up outpatient. The note revealed the Neurologist felt the findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare, progress brain infection that destroys cells that produce myelin, an insulating material for nerve cells). The resident's hospital course included a full stroke workup resulting in no findings of a stroke, Physical Therapy and Occupational Therapy evaluation, lab workup and inpatient neurology evaluation. Resident #49 was discharged back to the facility on 09/20/24 with orders to follow up with neurology outpatient.

A Nurse Practitioner note written by NP #1 revealed Resident #49 was evaluated on 09/23/24 after a reevaluation post hospitalization regarding altered mental status. The resident was noted to have been recently sent to the Emergency Department (ED) after being hit in the head by another resident. He was evaluated in the ED and cleared for discharge. However, after his return to the facility he had a decline with altered mental status and was sent back for further evaluation. Resident #49 was admitted for

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further neurological imaging. The plan included concussion/leukoencephalopathy/closed head injury. Neurology felt the resident had post concussive findings in the setting of extensive chronic progressive leukoencephalopathy. The hospitalist recommended a neurology follow-up.

A Nurse Practitioner note dated 10/21/24 written by NP #1 revealed she saw Resident #49 on this date for a reevaluation post-concussion. The note revealed the resident was recently sent to the Emergency Room after being hit in the head by another resident. Neurology felt the resident's MRI findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare, progress brain infection that destroys cells that produce myelin, an insulating material for nerve cells). The note revealed the Neurologist felt the findings could represent post concussive changes in the setting of extensive chronic progressive leukoencephalopathy (a rare, progress brain infection that destroys cells that produce myelin, an insulating material for nerve cells). The resident was discharged from the hospital back to the facility and had since followed up with neurology outpatient on 10/18/24. Neurology recommended a lumbar puncture, blood work to be completed prior to his follow up appointment in 3 months.

A review of Resident #49's significant change Minimum Data Set assessment dated 09/23/24 revealed he was cognitively intact. Resident #49 was coded as dependent for putting on/ taking off footwear, toileting hygiene, shower/bathing and lower body dressing. The resident was coded for toileting transfers not attempted and was dependent upon two staff member assistance for

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bed mobility rolling left and right and chair to bed transfers. He required maximum assistance from one staff member for eating.

On 11/19/24 at 3:12 PM an interview was conducted with Resident #49. During the interview Resident #49 stated he had gotten hit in the back of the head by Resident #79 a couple of months prior. The interview revealed he was sitting in the doorway when Resident #79 came at him from behind. Resident #49 revealed he did not recall any details about what had occurred after he was hit and did not remember going to the hospital after the incident. He felt his condition had changed since the incident and noted he could no longer transfer himself from his bed to the wheelchair or self-propel in his wheelchair. Resident #49 revealed he was no longer able to use his regular wheelchair, which was still located outside of his room, because he was no longer able to sit up in it. Resident #49 stated he was now confined to a specialized chair and was dependent upon staff for all activities of daily living and required the use of mechanical life for transfers. He stated he was unable to transfer himself to the toilet to use the restroom and was having to wear a brief, urinate on himself, and reliant on staff to change him.

An interview conducted on 11/20/24 at 11:47 AM with the Therapy Director revealed Resident #49 had been on the therapy caseload from 07/18/24 through 09/06/24. She stated at the time of his therapy discharge on 09/06/24 Resident #49 was able to bathe himself, complete toilet transfers, and was supervision assistance for bed to chair transfers. She stated he was independent with his mobility from the bed to the wheelchair. The interview revealed that following his hospital

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discharge on 09/20/24 he was placed back on the therapy caseload for Physical Therapy and Occupational Therapy on 09/25/24 through 10/16/24. She stated he had a significant decline in mobility after his return from the hospital. He was no longer able to sit up in a regular wheelchair and had to be placed in a specialized wheelchair that leaned back. Resident #49 required a mechanical lift for transfers and was ultimately discharged from therapy services because his condition did not improve. The Therapy Director stated based on her observation he had a significant change from his 09/06/24 evaluation to his 09/25/24 evaluation in mobility.

On 11/27/24 at 2:05 PM an interview was conducted with the Neurologist Physician Assistant (PA). She stated she had evaluated Resident #49 during his follow up appointment on 10/18/24. She stated the resident was being seen due to an abnormal brain MRI, white matter disease, left side numbness, incoordination and weakness. The PA stated she had only seen the resident during a one-time snapshot, and it is very hard to say the findings came directly from the altercation. She stated she had ordered follow up blood work, a lumbar puncture and was going to be reevaluating Resident #49 at the first of the year to see if there was a possible relationship between the altercation and the changes the resident has experienced.
On 11/20/24 at 11:02 PM an interview was conducted with the Medical Director (MD). The MD stated she had only been in the facility since September 2024 and was not familiar with Resident #49's prior state. She stated she knew of the incident occurring, but the on-call Nurse Practitioner was notified since the incident occurred on a weekend. The MD stated if

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Resident #49 had a change of condition he should have been sent to the hospital for an evaluation. A resident who experienced trauma to the head should be placed on neurological assessments. She stated a change of condition should have been recognized by the resident sliding out of his wheelchair, a decrease in mobility or increased confusion. The nurse was responsible for contacting the on-call provider and notifying them of the change of condition. The MD indicated the resident was sent to the hospital following a fall in the hallway and his CT at the hospital was negative, so he was sent back to the facility. The interview revealed Resident #49 continued to have symptoms of a concussion, so he was sent to the hospital for a reevaluation on 09/17/24. The MD explained it could take a couple of days for symptoms of a concussion to appear. She stated at the hospital there were changes from his previous MRI with a decreased signal to the brainstem which she felt couldn't have happened from a hit to the resident's head. Neurology was consulted while Resident #49 was hospitalized and mentioned post concussive findings in their note, however they were also ruling out a possible misdiagnosis in the past. The interview further revealed concussion symptoms would have included lightheadedness, light sensitivity and blurred vision, all which Resident #49 was noted to have during his 09/17/24 hospitalization.

On 11/20/24 at 2:51 PM an interview was conducted with the Director of Nursing (DON). The DON stated she was notified early in the morning around 9:00 on 09/14/24 that Resident #49 was hit in the head by Resident #79. She stated Resident #49 was sitting in his wheelchair in the doorway of the room and Resident #79

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wanted to get out of the room. The interview revealed a Unit Manager was in the building and she didn't recall her stating the resident had an injury at that time. The DON was notified by Unit Manager #1 around 3:00 PM that Resident #49 had experienced a change of condition, and she had called NP #2. The DON told Unit Manager #1 to activate EMS transport to the hospital. The DON stated she was then notified NP #2 was in the building and had turned EMS away. She was notified later in the shift that the staff had to send Resident #49 out due to a fall in the hallway. The DON indicated she knew the staff had completed action rounding that documented where the residents were in the facility every 15 minutes but was unsure about neurological assessments. She stated she had spoken to Nurse #3 and Nurse #4 regarding the incident but had not spoken with the NAs. The interview revealed she was unaware Resident #49 had experienced any change of condition on 09/14/24 but she would have expected nursing staff to complete vital signs and neurological assessments for a resident that was struck in the head.

On 11/20/24 at 3:17 PM an interview was conducted with the Administrator. During the interview he stated he was notified about the altercation on a weekend day. Staff had told him Resident #79 had "popped" Resident #49 on the back of the neck. The Administrator stated he knew staff were monitoring the resident and he had another issue and ended up having to go out to the hospital that evening.

The Administrator was notified of the Immediate Jeopardy on 11/20/24 at 4:17 PM.

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F 684	Continued From page 86 The facility provided the following Credible Allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance. - The facility failed to obtain vital signs and neurological checks and recognized Resident 49 had a change in condition after being hit in the back of the head by his roommate. On 09/14/2024 at 9:05 AM, Nurse #1 heard a loud hit or thud coming from across the unit. Nurse #1 then noted Resident #49's wheelchair rolling out from his room with him in the wheelchair and witnessed his roommate swing his arm with a fist and hit Resident #49 in the back of the head. The facility failed to provide ongoing monitoring when the staff failed to communicate amongst themselves that after the incident and Resident #49 had a room change and a change in nursing staff. Based on staff interview, Resident #49 had a significant change in condition as evidenced slumping in chair, changes in transfer mobility and bed mobility requiring additional staff to help resident to transfer, turn and reposition and more assistance with activities of daily living, and altered mental status. - The on-call Nurse Practitioner was notified at 7:00 PM after Resident #49 was noted to be lying on the floor after sliding out of his wheelchair. He was noted to have Altered Mental Status (AMS) and was sent to the hospital for further evaluation due to a concern for a concussion. - On 11/21/2024 & 11/22/2024 all current	F 684		

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residents were reviewed by a licensed nurse with vital signs obtained to determine if they are experiencing a current change in condition to include head trauma/injury which would require them to be sent out to the hospital for further evaluation and treatment. Residents identified to be having a change in condition, the medical provider is notified, and neuro-checks and/or vital signs were done after the change was noted. Each resident's licensed nursing review is noted in the electronic health record.

- On, 11/22/2024, the DON/RN Nurse Manager reviewed the 24-report for 11/21/2024 and 11/22/2024 to ensure no current changes in condition requiring notification to the Medical Provider for transfer to a higher level of care for further evaluation and treatment.

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

- On 11/21/2024 and 11/22/24, the Regional Director of Clinical Services re-educated the Director of Nursing and the Nurse Managers regarding ensuring a thorough report between nursing staff at any time when residents move rooms to ensure continuity of care and to establish a baseline in the event that there is a change in condition. Education also included obtaining vital signs and initiating and completing neurological checks when a resident experiences head trauma or if there is an unwitnessed event such as a fall for which the resident could have experienced head trauma. Shift-to-shift report is verbal and/or written and may include but not be limited acute changes in condition, infections,

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falls, blood sugars that are critical, held medications, PRN medications that were given, exacerbated behaviors, refusals of medications or care, neurological checks that are in place, safety checks that are in place. Education also included that with significant changes in condition such as significant changes in consciousness, mental status, mobility, strength and/or vital signs, there should be immediate notification the provider to send the resident out to a higher level of care for further evaluation and treatment, and the notification and the assessment is to be documented

- On 11/22/2024 the Director of Nursing and the Nurse Managers re-educated the Licensed Nurses to include agency staff regarding ensuring a thorough report between nursing staff to include the Certified Nurse Aides at any time including at beginning and end of shift and when residents move rooms to ensure continuity of care and to establish a baseline in the event that there is a change in condition. Nursing staff were re-educated on identifying a change in condition through observations, resident interactions and vital sign changes. Additionally, re-education to Licensed Nurses also include obtaining vital signs and initiating and completing neurological checks when a resident experiences head trauma or if there is an unwitnessed event such as a fall for which the resident could have experienced head trauma. Neuro checks are completed on a paper document. Included in a neurological check is the resident's level of consciousness, pupils' equal round and reactive to light and accommodation, hand grasps, motor functions, pain response, vital signs. Neurological checks are every 15 minutes x 4, then every 30 minutes x 4, then every hour x 4 and then every 4 hours x

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4 and then every shift for a total of 72 hours from the time of initiation. Licensed Nurses complete the neurological check sheets, and they are given to the DON or Nurse Manager upon completion. Education also included documenting assessments and completing neurological checks and upon completion they will be given to the Director of Nursing or Nurse Manager. Education completed via phone and in person.

- On 11/22/24, Nurse Aides were educated by the Licensed Nurse Manager that they are to report changes in resident condition to the Licensed Nurse. These changes may include but are not limited to changes in toileting, transfers, eating, mobility, skin changes, mental status changes, behaviors, refusals of care. Nurse aides are to report changes noted with residents immediately to the Licensed Nurse. Education completed via phone and in person.

- This education for the nursing staff will be the responsibility of the DON/Licensed Nurse Managers for current staff and will continue during the orientation period for any newly hired staff ongoing.

- An Ad-Hoc Quality Assurance Performance Improvement Committee was held on 11/21/2024, which included the Regional Clinical Director, Medical Director (via phone), the Director of Nursing, Administrator, Maintenance Director, Unit Managers, Social Service Director, Activities Director, Rehab Program Manager and a Certified Nursing Assistant to formulate and approve a plan of correction for the deficient practice.

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The Administrator will be responsible for the completion of the corrective action plan.

Alleged date of IJ removal: 11/23/2024

On 10/27/22, the credible allegation of Immediate Jeopardy removal date of 11/23/24 was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on obtaining vital signs and initiating and completing neurological checks when a resident experiences head trauma or if there is an unwitnessed event such as a fall for which the resident could have experienced head trauma and when to notify the physician. The interviewed staff explained that neurological assessments were completed on a paper document and included the resident's level of consciousness, pupils' equal round and reactive to light and accommodation, hand grasps, motor functions, pain response, vital signs. Neurological checks are every 15 minutes x 4, then every 30 minutes x 4, then every hour x 4 and then every 4 hours x 4 and then every shift for a total of 72 hours from the time of initiation. The staff stated they had also received education on ensuring a thorough report between nursing staff to include the Certified Nurse Aides at any time including at beginning and end of shift and when residents move rooms to ensure continuity of care and to establish a baseline in the event that there is a change in condition. Nursing staff were re-educated on identifying a change in condition through observations, resident interactions and vital sign changes. Nurse Aides were interviewed regarding that they are to report changes in resident condition to the Licensed Nurse. The staff stated changes may include changes in toileting, transfers, eating, mobility,

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skin changes, mental status changes, behaviors, refusals of care. The interviews revealed they were to notify the Nurse responsible immediately if they noticed any change of condition in the resident.

The IJ removal date of 11/23/24 was validated.

2. Resident #55 was admitted to the facility on 11/22/22 with diagnoses that included end stage renal disease, right below the knee amputation, abnormalities of gait/mobility and muscle weakness.

A review of the quarterly Minimum Data Set (MDS) dated 11/08/24 revealed Resident #55 was cognitively intact, had lower extremity impairment on one side, utilized a manual wheelchair for mobility, required supervision to moderate assistance with transfers, and received dialysis treatments. The MDS further revealed Resident #55 was not coded for receiving an anticoagulant.

A review of the Care Plan dated 11/13/24 indicated Resident #55 required minimal to extensive assistance with activities of daily living, was a right lower extremity amputee with a prosthesis, utilized a wheelchair to assist with mobility and received dialysis treatment 3 times a week.

A review of Driver #1's statement dated 11/15/24 indicated he picked up Resident #55 from the dialysis center, loaded him in the transportation van and secured his wheelchair. Driver #1 was pulling out of the parking lot onto the main road when he heard Resident #55 yelling "whoa, whoa," and he looked back to find Resident #55 had fallen backwards in his wheelchair. Driver #1

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immediately pulled over into a parking lot and stopped the van, waved down a person to help and they lifted Resident #55 back into an upright position. Driver #1 noted Resident #55 had a small amount of blood to the back of his head which he cleaned with an alcohol wipe. Driver #1 secured Resident #55's wheelchair, started driving back to the facility and called Unit Manager #1 to inform her of the incident. Upon returning to the facility, Driver #1 took Resident #55 to the nurse's station and informed the nurse of the incident.

An interview with Driver #1 on 11/19/24 at 2:02 PM indicated on 11/12/24 the Former Administrator trained him on how to properly secure a wheelchair in the facility van and on 11/13/24 he transported 3 residents to appointments without incident. Driver #1 revealed on 11/15/24 around 11:00 AM he picked up Resident #55 from the dialysis center, secured his wheelchair in the transport van, and when he drove out of the parking lot and turned right onto the main road, Resident #55 began yelling "whoa, whoa." Driver #1 stated he looked back and Resident #55 had fallen backwards in his wheelchair. Driver #1 indicated he drove about 200-300 feet, pulled over into a parking lot and stopped the van. He revealed he went to the back of the van and Resident #55 was tipped over in his wheelchair and lying on his right side. Driver #1 indicated he asked Resident #55 if he was ok and he said he was, so he waved down a person in the parking lot and they lifted Resident #55 back into an upright position. He revealed that Resident #55 had a little bit of blood on the back of his head which he cleaned with an alcohol wipe. He stated he secured Resident #55's wheelchair and drove him back to the

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facility. He indicated that while he was driving back to the facility, he called Unit Manager #1 and told her what happened. Driver #1 revealed when they arrived at the facility, he took Resident #55 to the nurse's station and informed Nurse #1 of the incident. Driver #1 stated that the training provided by the Former Administrator on 11/12/24 did not include education on what to do if a resident had a medical emergency, accident, fall or injury while he was transporting them in the van.

An interview was conducted with Unit Manager #1 on 11/20/24 at 10:06 AM. Unit Manager #1 revealed on 11/15/24 she received a phone call from Driver #1 informing her that Resident #55 fell backwards in his wheelchair and hit his head while being transported in the facility van. Unit Manager #1 indicated Driver #1 informed her he lifted Resident #55 back into an upright position and there was a little blood on the back of his head that he wiped off. She revealed Driver #1 reported no other injuries to Resident #55 so she told him to bring Resident #55 back to the facility.

A review of the facility incident report dated 11/15/24 written by Nurse #1 indicated Resident #55 was being transported in the facility van from dialysis and when the driver accelerated the van and turned right onto the main road, he fell backwards in his wheelchair and hit his head. Resident #55 returned to the facility and Nurse #1 completed a full body assessment. Resident #55 had an area to the back of his head with a small amount of bleeding, redness, and swelling. Resident #55 was alert and oriented and his vital signs were stable. Nurse #1 cleaned the area to his head and applied a border gauze dressing. Resident #55 was complaining of head pain and

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requested to go to the hospital. Nurse #1 notified the on-call physician and obtained an order to transfer Resident #55 to the emergency department (ED). Nurse #1 called 911 and Resident #55 was transported to the ED via emergency medical services for further evaluation.

An interview with Nurse #1 on 11/20/24 at 10:21 AM indicated she was assigned to Resident #55 on 11/15/24. She stated Driver #1 returned to the facility with Resident #55 after his dialysis appointment and informed her the resident fell backwards in his wheelchair in the van and hit his head on the floor. Nurse #1 revealed she completed a head-to-toe assessment and noted Resident #55 had a large swollen area to the back right side of his head with abrasions and a small amount of bleeding. She indicated she also completed a neurological assessment which was within normal limits and Resident #55 was alert, oriented and at his baseline. She stated she cleaned the area and applied a border gauze dressing (absorbent gauze pad with a sticky border to hold it in place). Nurse #1 indicated that Resident #55 was complaining of severe head pain, so she administered his pain medication ordered as needed. She revealed that Resident #55 requested to go to the hospital, so she called the on-call physician and obtained an order to transfer him to the ED. Nurse #1 stated she called 911 and Resident #55 was transported to the ED for further evaluation via emergency medical services.

An interview with Resident #55 on 11/19/24 at 12:36 PM indicated Driver #1 transported him to dialysis on 11/15/24 and on the way back to the facility he was driving out of the parking lot and

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turned right onto the main road and he fell backwards in his wheelchair and hit his head on the van floor. Resident #55 stated Driver #1 stopped the van and asked if he was injured, and he told him his head hurt. He stated that Driver #1 waved down a person to come and help and they lifted him back into an upright position. Resident #55 revealed that Driver #1 secured his wheelchair and drove him back to the facility. He stated a nurse assessed him when he returned to the facility, but he did not recall her name. He indicated he told the nurse he was having severe head pain and that he wanted to go to the hospital and she obtained an order from the on-call physician to send him to the ED. Resident #55 revealed the nurse called 911 and he was transferred to the ED for further evaluation.

A review of the emergency department (ED) records dated 11/15/24 revealed Resident #55 reported he fell backwards in his wheelchair in a transport van hitting his head on the van floor. He was noted to have a wound to the back of his head with the bleeding controlled prior to his arrival at the ED. A computed tomography (CT) scan of the head and spine, and x-rays of the pelvis and chest were obtained. The CT scan results were negative for intracranial hemorrhage (brain bleed) and fractures, the x-rays were negative for fractures and no treatment was required for the scalp abrasion. Resident #55 was stable and discharged back to the facility on 11/15/24 with diagnoses including closed head injury, scalp abrasion, and strain of the neck muscle and a new order for Acetaminophen 325 milligrams two tablets to be administered by mouth every 6 hours as needed.

An interview conducted with the Former

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Administrator on 11/19/24 at 3:08 PM revealed the training he provided to Driver #1 on 11/12/24 did not include what to do if a resident had a medical emergency, accident, fall or injury while he was transporting a resident in the van. The education included how to operate the van, using the electric lift and securing the wheelchair.

An interview was conducted with the Director of Nursing (DON) on 11/20/24 at 10:27 AM. The DON stated Driver #1 started transporting residents in the facility van on 11/13/24. She revealed she was not involved in Driver #1's training on 11/12/24. The DON indicated she was notified on 11/15/24 Resident #55 was not secured properly in the transport van, fell backwards in his wheelchair and hit his head on the floor. She indicated Driver #1 lifted Resident #55 back into an upright position, secured the wheelchair and returned to the facility. The DON revealed Nurse #1 assessed Resident #55 when he returned to the facility and noted an abrasion and swelling to the back of his head. She stated Nurse #1 notified the on-call physician and received an order for Resident #55 to be transferred to the ED for further evaluation. The DON indicated she suspended Driver #1 and the van was taken out of service pending an investigation. She revealed that Driver #1 should not have moved Resident #55 and should have called 911.

An interview conducted with the Medical Director on 11/20/24 at 11:01 AM indicated she was aware Resident #55 was being transported in the facility fan and fell backwards in his wheelchair hitting his head on the van floor. The Medical Director revealed that Resident #55 should have been assessed by a medical professional before he

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was moved to prevent further injury.

An interview with the Administrator on 11/19/24 at 3:30 PM revealed he started working at the facility on 11/12/24. He stated he was aware of the incident that occurred on 11/15/24 involving Resident #55. He indicated Driver #1 had not properly secured Resident #55's wheelchair and when the van started moving Resident #55 fell backwards in his wheelchair and hit his head on the van floor. The Administrator indicated Driver #1 lifted Resident #55 back into an upright position, secured his wheelchair and drove him back to the facility. The Administrator stated Driver #1 should not have moved Resident #55 and should have called 911.

The Administrator was notified of immediate jeopardy on 11/20/24 at 2:04 PM.

The facility provided the following credible allegation for immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the non-compliance:

On 11/15/2024 at approximately 11:20 AM Resident #55 had a fall in the facility van during return from dialysis when the wheelchair tipped backwards, and Resident #55 struck his head on the van floor resulting in an injury to the back of his head and pain. The facility Transportation Driver immediately pulled over to the next parking lot, flagged down someone in the parking lot and they lifted Resident #55 back into an upright position. Resident #55 was not assessed by a medical provider before he was moved from the floor of the van. The Facility Transportation Driver

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called the Unit Manager at the facility on the way back.

On 11/15/2024 at approximately 11:30 AM Resident #55 returned to the facility. The nurse immediately assessed Resident #55 including a Head-to-Toe assessment, Range of Motion all extremities, pupils equal, round and reactive to light and accommodation, and completed a pain assessment. Resident #55 was alert and oriented x 4 per baseline. Resident #55 sustained a hematoma to the back of his head with a small abrasion noted to the area. First aid was provided by the nurse to the area on resident's head, and medications administered per schedule and pain medication administered. The resident reported to the nurse that when the van moved, he fell backwards and hit his head. The nurse called 9-1-1 and sent Resident #55 out via EMS at approximately 12:01 PM. The Director of Nursing and the Nurse Practitioner were notified along with Resident #55's Responsible Party.

On 11/15/2024 the facility Transportation Driver was suspended pending investigation, and an investigation was immediately initiated by the Director of Nursing, which included interviewing the facility Transportation Driver. As per the facility Transportation Driver's interview and the visualization of return demonstration by the facility Transportation Driver, Resident #55 was strapped into the van with all 4 wheelchair restraints and the seatbelt. The wheelchair locks were also locked on both wheels. The facility Transportation Driver could not recall if he had been trained not to move the resident, notify the facility or call 911. The facility Transportation Driver stated he moved Resident #55 from the van floor out of instinct, as he just wanted to

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make sure Resident #55 was comfortable.

On 11/15/2024 the Director of Nursing scheduled all resident transport with contracted transportation company until further notice.

On 11/15/2024, at approximately 5:49 PM, Resident #55 returned from the Emergency Department status post Computed Tomography Scan which was negative. No orders were received from the Emergency Room. Upon return to the facility, neurological checks were initiated. Head to toe skin assessment and pain assessment completed. Resident #55 complained of headache, and Hydrocodone/APAP 5/325mg was administered by the nurse as ordered. Resident #55 was alert and oriented per baseline. Upon return to the facility the Nurse Practitioner was notified, and orders were obtained to apply ice to the to the back of Resident #55's head and an additional order to cleanse the area and apply a dry dressing to his head daily and as needed.

On 11/15/2024 Head-to-toe skin assessments were completed for all residents on the transport schedule for the facility van from 11/13/2024-11/15/2024 as a precaution since the Facility Transportation Driver had only started driving the van on 11/13/24. No concerns were identified.

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

On 11/15/2024, at approximately 12:20PM the Regional Clinical Director provided re-education

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by phone to the Administrator and Director of Nursing. This education included emergency protocols, including not moving the resident if an accident/event occurs on the facility or contracted vehicle, immediate notification to the facility and/or Administrator and the Director of Nursing, calling 9-1-1 and keeping the resident safe until Emergency Medical Services (EMS) arrives.

On 11/15/2024, at approximately 1:00 PM, Immediate re-education provided by the Director of Nursing to the facility Transportation Driver per facility written policy. This re-education included emergency protocols, including not moving the resident if an accident/event occurs on the facility or contracted vehicle, immediate notification to the facility and/or Administrator and the Director of Nursing, calling 9-1-1 and keeping the resident safe until Emergency Management Services (EMS) arrives.

On 11/15/2024, the Director of Nursing contacted the only contracted transportation company utilized by the facility. The 2 van drivers and the owner were educated via phone on emergency protocols, including not moving the resident if an accident/event occurs on contracted vehicle, immediate notification to the facility and/or Administrator and the Director of Nursing, calling 9-1-1 and keeping the resident safe until Emergency Management Services (EMS) arrives. The van drivers and the owner voiced understanding. A written copy of the policy was provided to the contracted transportation company. Per the contracted transportation company owner, this education will be added to the company orientation process for any new hires.

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F 684	Continued From page 101 On 11/15/2024 the Director of Nursing began education for all staff, including administration, housekeeping, laundry, dietary, maintenance, department managers and nursing including agency staff on the facility protocol if receive a call from the facility Transportation Driver or contracted transportation driver/company of an accident/event occurrence on the van. This education included immediately instructing the driver not to move the resident, ensure resident(s) were safe at all times, calling 9-1-1 and calling the facility Administrator and the Director of Nursing. This education was provided in person and via phone for the staff who were not working. This education was completed for all staff on 11/16/2024. This education will be added to the facility orientation program, including agency staff. Alleged Date of Immediate Jeopardy Removal: 11/19/24 The facility's credible allegation of immediate jeopardy removal was validated on 11/22/24. A review of the head-to-toe skin assessments for residents that were transported on the facility van 11/13/24 through 11/15/24 had been completed and no concerns were identified. Interviews conducted with the facility transport drivers indicated the DON provided education related to emergency protocols and what to do if a resident fell or was injured while they were transporting them in the van. The transportation drivers revealed the education also included the importance of calling 911, not moving the resident and keeping them safe until EMS arrived. Interviews conducted with nursing, housekeeping, dining and maintenance staff revealed they were educated on the protocol to follow when there	F 684		

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F 684	Continued From page 102 was a resident accident, injury or fall in the facility van and if they received a call from a transport driver concerning a resident incident to instruct them not to move the resident, call 911 and notify the Administrator and DON. The facility's immediate jeopardy removal date of 11/19/24 was validated.	F 684		
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 observations, record review, resident, Medical Director and staff interviews, the facility failed to provide safe van transportation when Driver #1 failed to secure Resident #55's wheelchair in the facility van per the manufacturer's instructions. On 11/15/24, during transport from the dialysis center, Driver #1 did not secure Resident #55's wheelchair in the facility van per the manufacturer's instructions, and when he drove out of the parking lot and turned right onto the main road, Resident #55 fell backwards in his wheelchair and hit his head on the van floor. Resident #55 was assessed by Nurse #1 when he returned to the facility, was noted to have an abrasion and swelling to the back of his head and was complaining of severe head pain. He was transported to the Emergency	F 689	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F689 On 11/15/2024 at approximately 11:20 AM Resident #55 had a fall in the facility van during return from dialysis when the	11/29/24

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F 689	Continued From page 103 Department (ED) for further evaluation and diagnosed with a closed head injury, scalp abrasion, and strained neck muscles. There was a high likelihood of a serious adverse outcome or injury when Resident #55's wheelchair was not secured in the transportation van per the manufacturer's instructions. Resident #55 was not receiving an anticoagulant (blood thinner). This deficient practice occurred for 1 of 9 residents reviewed for accidents (Resident #55). Immediate jeopardy began on 11/15/24 when Resident #55's wheelchair was not secured in the facility's transport van per the manufacturer's instructions, and he fell backwards in his wheelchair and hit his head on the van floor. Immediate jeopardy was removed on 11/19/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: A review of the manufacturer's instruction manual for the transport van 4-point wheelchair securement system provided by the facility read in part: Attach the tie-down (fabric strap connecting a hook and a floor anchor) anchor into the floor anchorages and lock them into place. Attach the 4 tie-down hooks to a solid part of the wheelchair frame below the seat ensuring the tie downs are fixed at approximately 45 degrees. Ensure all tie-downs are locked and properly tensioned (tightened).	F 689	wheelchair tipped backwards, and Resident #55 struck his head on the van floor resulting in an injury to the back of his head and pain. The facility Transportation Driver failed to provide safe van transportation for Resident #55 by not securing his wheelchair in the transportation van per the manufacturer’s instructions. On 11/15/2024 at approximately 11:30 AM Resident #55 returned to the facility. The nurse immediately assessed Resident #55 including Head-to-Toe assessment, Range of Motion all extremities, pupils equal, round and reactive to light and accommodation, and completed a pain assessment. Resident #55 was alert and oriented x 4 per baseline. Resident #55 sustained a hematoma to the back of his head with a small abrasion noted to the area. First aid was provided by the nurse to the area on resident’s head, and medications administered per schedule and pain medication administered. The resident reported to the nurse that when the van moved, he fell backwards and hit his head. The nurse called 9-1-1 and sent Resident #55 out via EMS at approximately 12:01 PM. The Director of Nursing and the	

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F 689	Continued From page 104	F 689		

A review of Driver #1's training records revealed a competency evaluation dated 11/12/24 completed by the Former Administrator that Driver #1 was reviewed for securing a wheelchair into the facility's transport van per the manufacturer's instructions and all competencies were checked as met.

Resident #55 was admitted to the facility on 11/22/22 with diagnoses that included end stage renal disease, right below the knee amputation, abnormalities of gait/mobility and muscle weakness.

A review of the quarterly Minimum Data Set (MDS) dated 11/08/24 revealed Resident #55 was cognitively intact, had lower extremity impairment on one side, utilized a manual wheelchair for mobility, required supervision to moderate assistance with transfers and was receiving dialysis treatment. The MDS further revealed Resident #55 was not coded for receiving an anticoagulant.

A review of the Care Plan dated 11/13/24 indicated Resident #55 required minimal to extensive assistance with activities of daily living, was a right lower extremity amputee with a prosthesis, utilized a wheelchair to assist with mobility and received dialysis treatment 3 days a week.

A review of the facility incident report dated 11/15/24 written by Nurse #1 indicated Resident #55 was being transported in the facility van from dialysis and when the van started moving forward, he fell backwards in his wheelchair and hit his head. Resident #55 returned to the facility and Nurse #1 completed a full body assessment. Nurse Practitioner were notified along with Resident #55's Responsible Party.

On 11/15/2024 the facility Transportation Driver
was suspended pending investigation, and
the facility van was removed from service until the Regional Maintenance Director inspection was complete. On 11/15/2024 an Investigation immediately initiated by the
Director of Nursing, which included an interview and the visualization of return demonstration by the facility Transportation Driver. The facility Transportation Driver stated that Resident #55 was strapped into the van with all 4 wheelchair restraints and the seat belt. The wheelchair locks were also locked on both wheels. The facility Transportation Driver stated he pulled out of the parking lot, turning right, when he heard Resident #55 say "whoa", he looked in the mirror and saw Resident #55 fall backward to the side. The conclusion is that a strap was not fully engaged in the track which allowed the wheelchair to come loose and fall backwards, whereby the resident hit his head.

On 11/15/2024, at approximately 5:49 PM, Resident #55 returned from the Emergency Department status post Computed Tomography Scan which was negative. No orders were received from the Emergency Room. Upon return to the facility, neurological checks

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F 689	Continued From page 105 Resident #55 had an area to the back of his head with a small amount of bleeding, redness, and swelling. Resident #55 was alert and oriented and his vital signs were stable. Nurse #1 cleaned the area to his head and applied a border gauze dressing (absorbent gauze pad with a sticky border to hold it in place). Resident #55 was complaining of head pain and requested to go to the hospital. The on-call physician was notified, an order was received and Resident #55 was transported to the emergency department (ED) via emergency medical services for further evaluation. A review of the ED records dated 11/15/24 revealed Resident #55 reported he fell backwards in his wheelchair in a transport van hitting his head on the van floor. He was noted to have a wound to the back of his head with the bleeding controlled prior to his arrival at the ED. A computed tomography (CT) scan of the head and spine, and x-rays of the pelvis and chest were obtained. The CT scan results were negative for intracranial hemorrhage (brain bleed) and fractures, the x-rays were also negative for any fractures and the scalp abrasion did not require any treatment. Resident #55 was stable and discharged back to the facility with diagnoses including closed head injury, scalp abrasion, and strain of the neck muscle. A review of Driver #1's statement dated 11/15/24 indicated he picked up Resident #55 from the dialysis center loaded him in the transportation van and secured his wheelchair. Driver #1 was pulling out of the parking lot onto the main road when he heard Resident #55 yelling "whoa, whoa," and he looked back to find Resident #55 had fallen backwards in his wheelchair. Driver #1	F 689	were initiated. Head to toe skin assessment and pain assessment completed. Resident #55 complained of headache, and Hydrocodone/APAP 5/325mg was administered by the nurse as ordered. Resident #55 was alert and oriented per baseline. Upon Resident #55's return to the facility the Nurse Practitioner was notified, and an order was given to apply ice to the back of Resident #55's head and an additional order to cleanse the area and apply a dry dressing to his head daily and as needed. On 11/15/2024 the Director of Nursing scheduled all resident transport with contracted transportation company until further notice. On 11/15/2024 Head-to-toe skin assessments were completed for all residents on the transportation schedule for the facility van from 11/13/2024-11/15/2024 as a precaution since van driver had only started driving the van on 11/13/2024. No concerns were identified. Alert and oriented residents that had been scheduled for transportation on the facility van from 11/13/2024-11/15/2024 were asked if they felt safe and secure on the van during transport. No concerns were identified. On 11/15/2024, at approximately 12:20 PM immediate education was	

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F 689	Continued From page 106 immediately pulled over into a parking lot and stopped the van, waved down a person to help and they lifted Resident #55 back into an upright position. Driver #1 noted Resident #55 had a small amount of blood on the back of his head which he cleaned with an alcohol wipe. Driver #1 secured Resident #55's wheelchair, started driving back to the facility and called Unit Manager #1 to inform her of the incident. Upon returning to the facility, Driver #1 took Resident #55 to the nurse's station and informed the nurse of the incident. In an interview with Driver #1 on 11/19/24 at 2:02 PM he indicated the Former Administrator trained him on how to secure a wheelchair in the facility van on 11/12/24. Driver #1 indicated he watched the Former Administrator secure a wheelchair in the van using the manufacturer instructions. Driver #1 stated the Former Administrator then observed him secure an empty wheelchair in the van, and then the Former Administrator sat in a wheelchair, he secured it in the van and drove the van out of the parking lot and on the main road for a few minutes to ensure the wheelchair was properly secured. Driver #1 indicated the Former Administrator filled out a vehicle safety and operation competency evaluation and he was checked off for meeting the competencies for proper placement and securement of the wheelchair. Driver #1 stated he started transporting residents in the facility van on 11/13/24 and transported 3 residents to appointments on that day without incident. Driver #1 indicated on 11/15/24 around 11:00 AM he picked up Resident #55 from the dialysis center, secured his wheelchair in the transport van, and started to drive out of the parking lot. He stated when he accelerated the van and turned onto the	F 689	provided via phone by the Regional Director of Clinical Services to the Administrator and Director of Nursing. This education included Vehicle Driver Safety Program, proper use of wheelchair securement devices per manufacturer's instructions, vehicle lift competency evaluation, placing the van out of service immediately, and not allowing the facility transportation driver to drive until investigation completed. On 11/15/2024, at approximately 3:00 PM, Immediate education provided by the Director of Nursing to the facility Transportation Driver. This written and verbal education included Vehicle Driver Safety Program, proper use of wheelchair securement devices as per manufacturer's instructions, vehicle lift competency evaluation, placing the van out of service immediately, not allowing the facility transportation driver to drive until investigation completed. On 11/15/2024, the Contracted Transportation company provided the facility with their policy and procedures for securing and strapping a wheelchair and competencies for the 2 current drivers. The education and competencies are completed upon hire and annually. On 11/18/2024 the facility Transportation Driver, Maintenance Director and Maintenance Assistant were re-educated by the Regional Maintenance Director on the Facility Vehicle Driver Safety Program, including proper use of	

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F 689	Continued From page 107 main road, Resident #55 began yelling "whoa, whoa," and when he looked back Resident #55 had fallen backwards in his wheelchair. Driver #1 indicated he drove about 200-300 feet, pulled over into a parking lot, and stopped the van. He stated he went to the back of the van and Resident #55 was tipped over in his wheelchair and lying on his right side. Driver #1 stated he observed that the front left anchor on the tiedown strap had come loose from the floor anchorage. He indicated he asked Resident #55 if he was ok and he said he was. Driver #1 stated he waved down a person in the parking lot to help and they lifted Resident #55 back into an upright position. Driver #1 revealed he secured Resident #55's wheelchair making sure all of the tie-down anchors were locked into the floor anchorages and then drove back to the facility. He stated that while he was driving back to the facility he called and reported the incident to Unit Manager #1. Driver #1 indicated when he arrived at the facility, he took Resident #55 to the nurse's station and reported the incident to Nurse #1. An interview with Resident #55 on 11/19/24 at 12:36 PM indicated the facility transports him to dialysis on Mondays, Wednesdays and Fridays. He stated Driver #1 transported him in the facility van for the first time on 11/13/24. Resident #55 revealed when the van was moving his wheelchair was moving around a little and he did not feel properly secured but did not report this to Driver #1. Resident #55 indicated Driver #1 transported him to dialysis on 11/15/24 and on the way back to the facility when he drove out of the parking lot and turned onto the main road, he fell backwards in his wheelchair and hit his head on the van floor. Resident #55 stated Driver #1 stopped the van and asked if he was injured, and	F 689	wheelchair securement devices ensuring proper tension of devices per manufacturer's instructions, with return demonstration, and competency check off completion, and validated facility Transportation Driver was able to safely operate facility van. This education will be added to the facility orientation program for new Transportation Drivers, Maintenance Director or Maintenance Assistant. This education and competencies will be completed annually for the current Transportation Driver, Maintenance Director and Maintenance Assistant. On 11/18/2024 the Regional Maintenance Director inspected the facility van. The Regional Maintenance Director placed the facility van back in service. The facility Transportation Driver resumed transportation for the facility on 11/19/2024. The Maintenance Director/ designee will observe 2 residents daily 5 times a week for 2 weeks, then 2 residents weekly for 10 weeks to ensure appropriate use of safety restraints/devices to wheelchairs prior to engaging the vehicle for transport. The Maintenance Director or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI	

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he told him his head hurt. He stated that Driver #1 waved down a person to come and help and they lifted him back into an upright position. Resident #55 revealed that Driver #1 secured his wheelchair and drove him back to the facility. He stated a nurse assessed him when he returned to the facility but he did not recall her name. Resident #55 indicated he told the nurse he was having severe head pain and that he wanted to go to the hospital. He revealed the nurse called 911 and he was transferred to the ED for further evaluation.

An interview was conducted with Unit Manager #1 on 11/20/24 at 10:06 AM. Unit Manager #1 revealed on 11/15/24 she received a phone call from Driver #1 informing her that Resident #55 fell backwards in his wheelchair while being transported in the facility's van. She stated she asked Driver #1 how it happened, and he told her the tie-downs were not secured properly and came loose. Unit Manager #1 indicated Driver #1 informed her he lifted Resident #55 back into an upright position and there was a little blood on the back of his head he wiped off. She revealed Driver #1 reported no other injuries, so she told him to bring Resident #55 back to the facility.

An interview with Nurse #1 on 11/20/24 at 10:21 AM indicated she was assigned to Resident #55 on 11/15/24. She stated Driver #1 returned to the facility with Resident #55 after his dialysis appointment and informed her the resident fell backwards in his wheelchair in the van and hit his head on the floor. Nurse #1 revealed she completed a head-to-toe assessment and noted Resident #55 had a large swollen area to the right back side of his head with abrasions and a small amount of bleeding. She indicated Resident #55

committee will make recommendations and
changes as indicated based upon the findings of the audits.

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did not have hair, so she was able to clean the area and applied a gauze border dressing. She stated that Resident #55 was complaining of severe head pain and requested to go to the hospital. She revealed she administered Resident #55 pain medication ordered as needed, called the on-call physician and obtained an order to transfer Resident #55 to the ED for further evaluation.

An interview conducted with the Former Administrator on 11/19/24 at 3:08 PM indicated on 11/07/24 the facility's transport driver resigned, and the facility's part time receptionist (Driver #1) was hired as the transport driver. He stated on 11/12/24 he trained Driver #1 by showing him how to secure a wheelchair in the transport van using the manufacturer instructions for the 4-point wheelchair securement system and then watched Driver #1 secure an empty wheelchair in the van. The Former Administrator revealed he then sat in a wheelchair while Driver #1 secured it in the van and drove the van out of the parking lot and on the main road. He indicated Driver #1 secured the wheelchair properly and no concerns were identified. The Former Administrator stated he filled out the facility's vehicle safety and operation competency evaluation and Driver #1 met all the competencies on the form including proper placement and securement of the wheelchair per the manufacturer instructions.

An interview conducted with the Medical Director on 11/20/24 at 11:01 AM indicated she was aware of the van incident that occurred with Resident #55. She stated she was informed Resident #55's wheelchair was not secured properly in the transport van and when the van started moving, he fell backwards in his wheelchair hitting his

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head on the van floor. The Medical Director revealed that residents should be secured properly in the transport van and a resident that fell should be evaluated by a medical professional prior to being moved to prevent further injury.

An interview with the Administrator on 11/19/24 at 3:30 PM revealed he started working at the facility on 11/12/24. He stated he was aware of the incident that occurred on 11/15/24 involving Resident #55. He indicated Driver #1 had not secured Resident #55's wheelchair and when the van started moving Resident #55 fell backwards in his wheelchair and hit his head on the van floor. The Administrator indicated Driver #1 lifted Resident #55 back into an upright position, secured his wheelchair and drove him back to the facility. The Administrator stated Resident #55's wheelchair should have been properly secured in the transport van.

The Administrator was notified of immediate jeopardy on 11/20/24 at 2:04 PM.

The facility provided the following credible allegation for immediate jeopardy removal:

Identify those residents who have suffered, or are likely to suffer a serious adverse outcome as a result of the non-compliance:

On 11/15/2024 at approximately 11:20 AM Resident #55 had a fall in the facility van during return from dialysis when the wheelchair tipped backwards and Resident #55 struck his head on the van floor resulting in an injury to the back of his head and pain. The facility Transportation Driver failed to provide safe van transportation for Resident #55 by not securing his wheelchair in

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the transportation van per the manufacturer's instructions.

On 11/15/2024 at approximately 11:30 AM Resident #55 returned to the facility. The nurse immediately assessed Resident #55 including Head-to-Toe assessment, Range of Motion all extremities, pupils equal, round and reactive to light and accommodation, and completed a pain assessment. Resident #55 was alert and oriented x 4 per baseline. Resident #55 sustained a hematoma to the back of his head with a small abrasion noted to the area. First aid was provided by the nurse to the area on resident's head, and medications administered per schedule and pain medication administered. The resident reported to the nurse that when the van moved, he fell backwards and hit his head. The nurse called 911 and sent Resident #55 out via emergency medical services at approximately 12:01 PM. The Director of Nursing and the Nurse Practitioner were notified along with Resident #55's Responsible Party.

On 11/15/2024 the facility Transportation Driver was suspended pending investigation, and the facility van was removed from service until the Regional Maintenance Director inspection was complete. On 11/15/2024 an Investigation immediately initiated by the Director of Nursing, which included an interview and the visualization of return demonstration by the facility Transportation Driver. The facility Transportation Driver stated that Resident #55 was strapped into the van with all 4 wheelchair restraints and the seat belt. The wheelchair locks were also locked on both wheels. The facility Transportation Driver stated he pulled out of the parking lot, turning right, when he heard Resident #55 say "whoa," he

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looked in the mirror and saw Resident #55 fall backward to the side. The conclusion is that a strap was not fully engaged in the track which allowed the wheelchair to come loose and fall backwards, whereby the resident hit his head.

On 11/15/2024, at approximately 5:49 PM, Resident #55 returned from the Emergency Department status post Computed Tomography Scan which was negative. No orders were received from the Emergency Room. Upon return to the facility, neurological checks were initiated. Head to toe skin assessment and pain assessment completed. Resident #55 complained of headache, and Hydrocodone/Acetaminophen 5/325mg was administered by the nurse as ordered. Resident #55 was alert and oriented per baseline. Upon Resident #55's return to the facility the Nurse Practitioner was notified, and an order was given to apply ice to the back of Resident #55's head and an additional order to cleanse the area and apply a dry dressing to his head daily and as needed.

On 11/15/2024 the Director of Nursing scheduled all resident transport with contracted transportation company until further notice.

On 11/15/2024 Head-to-toe skin assessments were completed for all residents on the transportation schedule for the facility van from 11/13/2024-11/15/2024 as a precaution since van driver had only started driving the van on 11/13/2024. No concerns were identified. Alert and oriented residents that had been scheduled for transportation on the facility van from 11/13/2024-11/15/2024 were asked if they felt safe and secure on the van during transport. No

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concerns were identified.

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

On 11/15/2024, at approximately 12:20 PM immediate education was provided via phone by the Regional Director of Clinical Services to the Administrator and Director of Nursing. This education included Vehicle Driver Safety Program, proper use of wheelchair securement devices per manufacturer's instructions, vehicle lift competency evaluation, placing the van out of service immediately, and not allowing the facility transportation driver to drive until investigation completed.

On 11/15/2024, at approximately 3:00 PM, Immediate education provided by the Director of Nursing to the facility Transportation Driver. This written and verbal education included Vehicle Driver Safety Program, proper use of wheelchair securement devices as per manufacturer's instructions, vehicle lift competency evaluation, placing the van out of service immediately, not allowing the facility transportation driver to drive until investigation completed.

On 11/15/2024, the Contracted Transportation company provided the facility with their policy and procedures for securing and strapping a wheelchair and competencies for the 2 current drivers. The education and competencies are completed upon hire and annually.

On 11/18/2024 the facility Transportation Driver, Maintenance Director and Maintenance Assistant

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING & REHABILITATION	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

(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 689	Continued From page 114	F 689		

were re-educated by the Regional Maintenance Director on the Facility Vehicle Driver Safety Program, including proper use of wheelchair securement devices ensuring proper tension of devices per manufacturer's instructions, with return demonstration, and competency check off completion, and validated facility Transportation Driver was able to safely operate facility van. This education will be added to the facility orientation program for new Transportation Drivers, Maintenance Director or Maintenance Assistant. This education and competencies will be completed annually for the current Transportation Driver, Maintenance Director and Maintenance Assistant.

On 11/18/2024 the Regional Maintenance Director inspected the facility van. The Regional Maintenance Director placed the facility van back in service.

The facility Transportation Driver resumed transportation for the facility on 11/19/2024.

Alleged Date of Immediate Jeopardy Removal: 11/19/2024

The facility's credible allegation of immediate jeopardy removal was validated on 11/22/24. Observations were conducted of transport drivers securing a wheelchair for transport according to the manufacturer instructions which included securing the tie-down anchors into the floor anchorages and locking them into place. A review of the head-to-toe skin assessments for residents that were transported on the facility van 11/13/24 through 11/15/24 had been completed and no concerns were identified. Interviews conducted with the facility transporters revealed education

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F 689	Continued From page 115 was provided by the Regional Director of Maintenance which included vehicle driver safety and how to properly secure a resident in the facility van using the 4-point wheelchair securement system per the manufacturer's instructions. The facility transporters also stated they had to verbalize their understanding of the education and complete a return demonstration of how to properly secure a wheelchair in the facility van. An interview conducted with the Regional Director of Maintenance indicated he completed a safety inspection of the wheelchair securement system in the facility van and no concerns were identified. The Regional Director of Maintenance stated he provided education to the facility transporters on how to use the 4-point securement system per the manufacturer's instructions and observations of return demonstrations by the drivers indicated they were able to properly secure a resident in the van. The facility's immediate jeopardy removal date of 11/19/24 was validated on 11/22/24.	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an	F 727		11/29/24

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F 727	Continued From page 116 average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 13 of 155 days reviewed for sufficient staffing. This deficient practice had the potential to affect all facility residents. Findings included: Review of the daily assignment schedules from June 22, 2024, to November 22, 2024, revealed the facility failed to provide 8 hours of Registered Nurse (RN) coverage on the following dates: 7/5/2024, 7/6/2024, 7/7/2024, 7/20/2024, 8/17/2024, 8/18/2024, 8/24/2024, 9/1/2024, 9/2/2024, 9/7/2024, 9/8/2024, 9/14/2024, and 9/15/2024. An interview was completed with the facility Scheduler on 11/21/2024 at 1:26 PM. During the interview the Scheduler reported there were no RN hours listed on the staffing sheets due to not having any RNs on the schedule. The Scheduler explained that there had been a large amount of staff turnover, including RNs, since the facility changed ownership in June 2024. She further explained the facility had been using staffing agencies but could not get any RN coverage when it was needed, however the facility was in the process of hiring RN's. During the interview the above schedules were reviewed with the facility Scheduler to verify there had been no RNs scheduled to work on those days. On 11/22/2024 at 10:03 AM an interview was completed with the Director of Nursing (DON)	F 727	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F727 The facility failed to have scheduled a Registered Nurse (RN) for at least 8 hours for 13 of 155 days. Current staffing schedules from 11/30/2024 to 12/31/2024 were reviewed by the Director of Nursing to ensure 8 consecutive hours of RN coverage. No areas of concerns were noted. The scheduling coordinator was re-educated by the Regional Clinical Director on RN staffing requirements, including 8 hours of consecutive RN hours 7 days a week 11/21/2024. The Director of Nursing/ Designee will audit staffing schedules 5 times a week for 12 weeks to ensure 8 hours of consecutive RN coverage daily. The Human Resources	

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F 727	Continued From page 117 who had been at the facility since August 2024. During the interview the DON reported she was aware there had been issues related to RN staffing, including the lack of RNs in supervisory roles. She explained the facility was in the process of hiring RNs, including an Assistant Director of Nursing (ADON) and Unit Manager roles. During an interview with the prior Administrator on 11/22/2024 at 11:03 AM he revealed he was aware RN coverage had been an issue at the building since June 2024 after it changed ownership. The Administrator reported many nurses, including RNs, had to be let go and the facility was almost all agency staff except for a few Medication Aides. The Administrator explained he was aware the Scheduler had difficulty filling the RN spots that were open, and the facility was in the process of hiring additional RNs.	F 727	Manager/Designee will review time clock punches 5 times a week for 12 weeks to ensure 8 hours of consecutive RN coverage. The Director of Nursing, Human Resource Manager or designee(s) will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		12/18/24

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F 758	Continued From page 118 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Psychiatric Services Nurse Practitioner (NP) interviews, the facility failed to conduct an Abnormal Involuntary Movement Scale (AIMS) assessment used to monitor abnormal bodily	F 758	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan	

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F 758	Continued From page 119 movements related to the use of psychotropic medications for 1of 5 residents (Resident #69) reviewed for unnecessary medications. The findings included: Resident #69 was admitted to the facility on 4/12/2024 with diagnoses that included anxiety disorder, major depressive disorder, and personal history of other mental and behavioral disorders. Review of physician orders for Resident #69 revealed the following orders: Quetiapine 300 milligrams (MG) (an antipsychotic medication), to be given at bedtime dated 4/12/2024. A review of Resident #69's care plan last reviewed on 8/13/2024 revealed a goal that the diagnosis will be managed with medication therapy evidenced by no changes in mood or behavior within the next review. The interventions in place included note signs and symptoms of changes in mood and behavior, note resident concerns of depression, medical regimen as ordered, and notify physician of changes, and treat as ordered. Review of quarterly Minimum Date Set (MDS) assessment date 10/8/2024 revealed Resident #69 was receiving antipsychotic. There were no mood indicators or behaviors marked on the assessment. A review of Resident #69's Medication Administration Record (MAR) for the months of May 2024 and November 2024 revealed the resident was receiving the antipsychotic	F 758	of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F758 1)Resident #69 AIMs (Abnormal Involuntary Movement) assessment was completed on 12/13/2024. 2)All residents receiving antipsychotic medications have the potential to be affected. On 12/13/2024, the Director of Nursing and Nursing Administration completed an audit of residents receiving antipsychotic medications to ensure AIMs assessments were completed. Any identified areas of concern were addressed on 12/13/2024. 3)The Director of Nursing/Designee re-educated Nursing Administration and Licensed Nurses on completing AIMs assessment for residents receiving antipsychotic medications at time of admission, new orders, and at least every 6 months. This education was completed on 12/17/2024. This education will be added to the facility orientation program for all newly hired Nursing Administration, Licensed Nurses, including agency Licensed Nurses. 4)The Director of Nursing/Designee will review all new orders, including new admission orders 5 times a week	

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F 758	Continued From page 120 medication, Quetiapine 300 mg at bedtime for depression. Review of the most recent Pharmacy note for Resident #69 dated 11/6/2024 revealed the last AIMS assessment was completed in May of 2024. A review of Resident #69's physician orders dated 11/13/2024 showed orders in place to monitor behaviors and side effects every shift related to the use of antipsychotic medications. Further review of Resident #69's medical record revealed that there were no AIMS assessments completed after May 2024. An observation and interview were conducted on 11/18/2024 at 10:59 AM of Resident #69. She was observed lying in bed with no signs of distress. Resident #69 reported she had been receiving her medications daily. There were no signs of abnormal bodily movement noted, however Resident #69 said she did require assistance with her activities of daily living (ADL). During an interview on 11/21/2024 at 11:40 AM with the Regional MDS Coordinator who had only been with the facility for a couple of months, it was revealed the AIMS assessment was referred to as an UDA (User-Defined Assessment) in the computer system. She further explained, all UDAs like the AIMS assessment were to be completed by nursing quarterly so the MDS nurses could complete their assessments using the information. The Regional MDS Coordinator also said the Director of Nursing (DON) should be notified of any missing UDAs. The Regional MDS Coordinator could not say why the AIMS	F 758	for 12 weeks to ensure all residents with new orders for antipsychotic medications have an AIMs assessment completed. The Director of Nursing/Designee will review all residents with orders for antipsychotic medications monthly for 3 months to ensure AIMs assessment are completed as per policy. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility□s monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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F 758	Continued From page 121	F 758		

assessments for Resident #69 had not been completed.

An interview was completed on 11/21/2024 at 2:25 PM with Unit Manager (UM) #1. During the interview UM 1 reported the AIMS assessment should be completed at least quarterly, and they were completed in the computer system. There were no paper copies of the AIMS assessment. UM #1 further explained the AIMS assessments were usually scheduled in the computer system by a MDS nurse or the former Assistant Director of Nursing (ADON). UM #1 said she was not sure why the assessments had not been scheduled.

An interview was conducted on 11/22/2024 at 10:03 AM with the DON. During the interview the DON reported there had been confusion related to who was responsible for triggering the UDAs, including the AIMS assessment, and they had to be rescheduled several times and somehow some of them were missing. The DON explained the scheduled UDAs disappeared due to a glitch in the computer system. The DON said the AIMS assessment should have been completed on Resident #69. She further explained the AIMS assessment needed to be completed quarterly and with any medication changes, especially on residents that receive antipsychotic medications.

On 11/22/2024 at 11:19 AM a telephone interview was conducted with the Psychiatric NP. During the interview the NP said it would be very important to monitor any abnormal bodily movements, especially if the resident was receiving antipsychotic medications. The NP explained the AIMS test should have been completed quarterly on Resident #69 due to her use of antipsychotic medication.

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F 760 SS=G	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 observations, record review, and staff, resident, Nurse Practitioner and Pharmacist interviews, the facility failed to ensure a resident was free of significant medication errors when they failed to administer a monthly dose of Aripiprazole (antipsychotic medication) as prescribed by the physician from July 2024 through November 2024 for 1 of 3 residents reviewed for medication errors (Resident #2). Resident #2 stated she felt like something was wrong a couple of weeks ago because if anyone tried to talk to her, she would break down and cry uncontrollably, even waking up at night with tears running down her face. The findings included: Resident #2 was admitted to the facility on 06/29/23 with diagnoses that included manic depression (bipolar disorder). A Physician order dated 10/18/23 revealed an order for Lithium Carbonate tablet extended release 450 milligram (mg) give one tablet orally at bedtime related to bipolar disorder, current episode manic severe with psychotic features. Resident #2's quarterly Minimum Data Set (MDS) assessment dated 10/10/24 revealed Resident #2 was cognitively intact with no behaviors. Resident #2 did not receive any antipsychotic medication	F 760	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F760 1)Resident #2 received Aripiprazole 300mg injection per physician's order. 2)All residents receiving antipsychotic injections have the potential to be affected. On 12/1/2024, the Weekend Nurse Manager completed an audit of all residents receiving antipsychotic injections for the last 30 days to ensure medications were ordered from the pharmacy and given per order. Any identified areas of concern were addressed. 3)The Director of Nursing/Designee re-educated all Licensed Nurses, including agency Licensed Nurses	12/3/24

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F 760	Continued From page 123 during the assessment period. A Physician order dated 04/16/24 revealed an order for Aripiprazole Intramuscular extended-release suspension prefilled syringe 300 milligram (mg). Inject 300 mg intramuscularly one time a day every 30 days related to bipolar disorder, with episodes of manic severe behaviors and psychotic features. Review of Resident #2's Medication Administration Record (MAR) for July 2024 revealed the medication was scheduled to be administered on 07/15/24 however the block on the MAR was left blank. Review of Resident #2's Medication Administration Record (MAR) for August 2024 revealed the medication was scheduled to be administered on 08/14/24 and was initialed as administered by Nurse #5. On 11/25/24 at 2:43 PM an interview was attempted with Nurse #5 who no longer was an employee of the facility. A return phone call was not received. Review of Resident #2's Medication Administration Record (MAR) for September 2024 revealed the medication was scheduled to be administered on 09/13/24 and was initialed as administered by Nurse #7. On 11/25/24 at 11:10 AM an interview was attempted with Nurse #7 who no longer was an employee of the facility. A return phone call was not received. Review of Resident #2's Medication	F 760	on reordering antipsychotic injection medications, notification of physician/Nurse Practitioner and pharmacy if medication has not been delivered, obtaining new orders as indicated, and documentation. This education was completed on 12/2/2024. This education will be added to the facility orientation program, including newly hired Licensed Nurses and agency Licensed Nurses. 4)The Director of Nursing/Designee will audit all antipsychotic injection medications weekly for 12 weeks to ensure medications are available and administered per physician orders. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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F 760	Continued From page 124	F 760		

Administration Record (MAR) for October 2024 revealed the medication was scheduled to be administered on 10/13/24 and was initialed as not administered by coding a 9 on the MAR by Nurse #6.

On 11/21/24 at 11:54 AM an interview was conducted with Nurse #6. She stated she documented Resident #2's medication as not administered because it was not in the medication cart or in the medication storage room on the date it was scheduled 10/13/24. The interview revealed the nurses were responsible for a lot of tasks during the day and she was unsure if she had contacted the pharmacy regarding reordering the resident's medication. Nurse #6 stated the typical process for the medication was to reorder it monthly. A reorder involved filling out a reorder form that would be faxed to the pharmacy. She stated she would have removed the sticker from the medication (if it had been available) and placed it onto the form. If the medication was not in the facility the orders could be written on the form and sent to the pharmacy requesting, it to be refilled. Nurse #6 stated she would have passed along the information of the resident's medication not being on the cart to the oncoming nurse for second shift (Nurse #8) so she would know to administer the medication once it arrived from pharmacy. Nurse #6 stated she had not observed Resident #2 crying or having any type of behaviors from not receiving her medication.

On 11/22/24 at 11:37 AM an interview was conducted with Nurse #8. Nurse #8 stated she had received report from Nurse #6 on 10/13/24. The interview revealed she did not recall Nurse #6 informing her that Resident #2's medication

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was not in the facility or that she had not received her intramuscular injection. Nurse #6 stated the medication would not have shown on the MAR for her to administer because at 3:00 PM an entire new set of medication shows up in the computer and the first shift medication would no longer be shown on her screen. She stated she was unaware Resident #2 had not received her medication but had not witnessed the resident having any side effects from not receiving it. The interview revealed the resident seemed to be attending activities in the facility and Nurse #8 had not witnessed the resident crying.

Review of Resident #2's Medication Administration Record (MAR) for November 2024 revealed the medication was scheduled to be administered on 11/12/24 and was initialed as administered by Nurse #1.

On 11/21/24 at 11:53 AM an interview was conducted with Nurse #1. Nurse #1 stated she had initialed the MAR by mistake on the date of 11/12/24 for Resident #2's medication because she knew the medication was not available and in the facility on that date. She stated she must have just clicked the box as administered on accident and she would correct the MAR. The interview revealed the process for reordering a medication would include faxing a reorder form to pharmacy or calling them. She stated because it was a monthly injection it would have to be reordered on a monthly basis. Nurse #1 indicated the pharmacy was good about sending the medication with the next delivery upon request. The interview revealed she did not reorder the medication on 11/12/24 when she noticed it was unavailable because she stated the nurses had a lot of tasks in the facility and had just forgotten to

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call the pharmacy.

On 11/18/24 at 11:58 AM an interview was conducted with Resident #2. Resident #2 stated she had been having issues not receiving her medication Aripiprazole and she could not recall the last time she had received the medication. She stated she felt like something was wrong a couple of weeks ago because if anyone tried to talk to her, she would break down and cry uncontrollably. Resident #2 indicated she had voiced her concerns to staff in the facility (names she could not recall) but nobody had told her anything about her medication. Resident #2 stated she was feeling a little better now, but she was taking the medication because she was bipolar. She stated she was waking up in the middle of the night with tears running down her face and knew something was wrong. The interview revealed staff would say they were going to check on the medication but would never return to the room.

An interview conducted on 11/25/24 at 10:23 AM with the Activities Director revealed Resident #2 often attended activities in the facility and always attended bingo. She stated Resident #2 had been feeling down and depressed within the last several weeks. The Activities Director stated several weeks ago Resident #2 did not attend bingo, which she never misses. She went to the resident's room to see what was wrong and the resident was tearful saying she was feeling depressed, and that something was wrong. The Activities Director stated she notified Social Worker #1 of the incident.

On 11/24/24 at 10:36 AM an interview was conducted with Social Worker (SW) #1. During

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the interview she stated she was notified several weeks ago by the Activities Director that Resident #2 seemed depressed. She stated she went to the resident's room, and she was tearful, stating she felt down and depressed and had been feeling that way for some time. SW #1 stated she reported the information to nursing staff (names she could not recall) but knew SW #2 had seen the resident following her telling the nursing staff the resident was tearful.

On 11/21/24 at 3:15 PM an interview was conducted with Social Worker (SW)# 2. SW #2 stated she was part of the psychiatric therapy program and completed talk therapy with the residents in the facility. The interview revealed she had seen Resident #2 on 11/12/24. Resident #2 had reported to her she had bipolar disorder and had recently been waking up crying. Resident #2 reported to SW#2 that she felt her medication was not working and she was experiencing increased anxiety. SW #2 stated she notified Nurse Practitioner #4 after her visit that Resident #2 would be a good person for her to see during her next visit to the facility.

On 11/22/24 at 11:10 AM an interview was conducted with Nurse Practitioner (NP) #4. NP #4 stated she was the facility Psychiatric NP and had taken over the role in October 2024. The interview revealed she had not yet seen Resident # 2, however was notified by SW #2 that the resident needed to be evaluated because she had a question about her medication. NP #4 revealed she had seen Resident #2 the week after being told by SW #2. However, the resident stated to her she no longer had a question about her medication. NP #4 stated if Resident #2 was not getting the medication Aripiprazole, a monthly

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injection then that would explain why she was having episodes of increased crying. NP #4 indicated symptoms of abruptly stopping intramuscular Aripiprazole include crying, mood swings which would be a problem for the resident. The interview revealed that stopping any antipsychotic medication abruptly would be a significant medication error because the medication must be tapered down under medical supervision. Reducing the dosage by 10-50 % over a duration of 1 to 2 weeks or longer. Otherwise, the resident would have symptoms of withdrawal which could include mood swings, crying, insomnia and trouble falling asleep.

On 11/22/24 at 11:44 AM an interview was conducted with the Pharmacist. During the interview he stated Resident #2's Aripiprazole Intramuscular for extended-release suspension prefilled syringe 300 milligram (mg) had not been refilled from the pharmacy since 07/15/24. The Pharmacist stated the facility would not have obtained the medication from any other pharmacy. He stated unless the nursing staff placed a reorder form requesting the medication it would not have triggered for them to refill or brought to their attention. The Pharmacist indicated a result of the resident not receiving the medication could have been a psychotic event. He stated the nurses, and physician should be monitoring closely for any symptoms of a psychotic event such as an increase of behaviors. The interview revealed Resident #2 was also receiving an antimanic medication which would have controlled some of her bipolar depression symptoms.

On 11/22/24 at 10:58 AM an interview was conducted with the Director of Nursing (DON).

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F 760	Continued From page 129 The DON stated it was the nurse's responsibility to reorder the medication, the sticker had to be pulled, placed on a reorder sheet and faxed to the pharmacy. She stated she had not heard of any issues with Resident #2's medication. After learning of the missed medication, the DON stated the nurses should have alerted her that the medication was not in the building and called the pharmacy. The DON stated the medication could have been delivered from the pharmacy within 2 to 3 hours if it was placed as a STAT (immediate) order refill. The interview revealed the nurses had not placed an order with pharmacy to have the medication refilled.	F 760		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential	F 842		12/18/24

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all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 131 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Nurse Practitioner, and Consultant Pharmacist interviews the facility failed to maintain documentation of the pharmacist's Monthly Medication Reviews (MMRs) in the medical record and available for review for 2 of 5 residents reviewed for unnecessary medications (Resident #9 and Resident #69). The findings included: a. Resident #9 was admitted to the facility on 3/22/2024 with diagnoses that included Post Traumatic Stress Disorder (PTSD), unspecified dementia, anxiety disorder, pseudobulbar effect (sudden uncontrolled and inappropriate crying and/or laughing), and depression. Review of physician orders revealed the following: Lorazepam 0.5 milligrams (MG), (a medication to treat anxiety), to be given three times a day for agitation ordered on 3/27/2024 and last revised on 10/20/2024. Depakote Sprinkles delayed release sprinkles 125 mg, (a medication used as a mood stabilizer), give 2 capsules by mouth three times a day for dementia dated 8/15/2024. Sertraline oral table 50 mg, give 1.5 tablets (a medication used to treat anxiety and depression),	F 842	Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance. F842 1)The Director of Nursing reviewed Resident # 9 Pharmacy Consult reports on 12/13/2024 for July, August, and October. Resident #9 was seen by the Pharmacy Consultant for the months of July, August and October as indicated in Resident #9s electronic medical record. Resident #9 did not have Monthly Medication Reviews (MMRs) Physician recommendations for July, August, and October. The Director of Nursing reviewed Resident #69 Pharmacy Consult reports on 12/13/2024 for July, August, September, October and November. Resident #69 was seen by the Pharmacy Consultant	

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F 842	Continued From page 132 by mouth one time a day related to anxiety dated 8/15/2024. Review of quarterly Minimum Data Set (MDS) assessment dated 8/28/2024 indicated Resident #9 had severe cognitive impairment with no behaviors. The MDS was also marked for antianxiety and antidepressant medication use. A review of Resident #9's electronic Medication Administration Record (MAR) for the months of August 2024, September 2024, October 2024, and November 2024 revealed Depakote, Lorazepam, and Sertraline had all been administered daily. There were orders on the MAR to monitor for behaviors and side effects related to the use of the medications. Review of a Pharmacy Medication Regimen Review (MRR) report dated 9/25/2024 showed Resident #9 was receiving Lorazepam 0.5 mg, three times a day for agitation, Sertraline 75 mg, daily for anxiety, and Depakote 125 mg, 2 capsules three times a day for dementia with behavioral disturbance. The report also revealed a dose reduction was contraindicated because the benefits outweighed risks for the resident and a reduction was likely to impair Resident #9's function and/or cause psychiatric instability. The bottom of the form showed the provider reviewed and signed the recommendation. There were no Pharmacy MMR reports for the months of July, August, or October. b.Resident #69 was admitted to the facility on 4/12/2024 with diagnoses that included anxiety	F 842	for the months of July, August, September, October, and November as indicated in Resident #69s electronic medical record. Resident #69 did no have Monthly Medication Reviews (MMRs) Physician recommendations for July, August, September, October or November. 2)All residents have the potential to be affected. The Director of Nursing/ Designee reviewed the Pharmacy Consultant Report for the last 30 days to ensure all current residents were reviewed and Monthly Medication Reviews (MMRs) received were reviewed by the Physician or Nurse Practitioner and uploaded to the residents individual electronic medical record as indicated. This was completed on 12/13/2024. 3)The Regional Clinical Director re-educated the Director of Nursing, Administrator and Medical Records that Monthly Medication Reviews (MMRs) received with physician recommendations will be uploaded to each individual residents electronic medical records once completed by the physician, as indicated. This education was completed on 12/13/2024. This education will be added to the facility orientation program to include any newly hired Director of Nursing, Administrator and/or Medical Records,	

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F 842	Continued From page 133 and major depressive disorder. Review of physician orders revealed the following: Buspirone 5 mg (antianxiety medication), give 3 times a day for anxiety dated 11/4/2024. Quetiapine 300 mg (antipsychotic medication), give 1 tablet at bedtime dated 4/12/2024. Duloxetine capsule delayed release 60 mg (antidepressant medication), give 1 daily for depression dated 8/14/2024. Review of Resident #69's care plan dated 5/2/24 and last revised on 10/7/2024 revealed a care plan in place to monitor for side effects related to the use of psychotropic medications. A review of the quarterly MDS assessment dated 10/8/2024 revealed Resident #69 was cognitively intact and was marked for antipsychotic and antidepressant medication. The MDS was also marked for no gradual dose reduction (GDR)attempted or documented during the review period. Review of Resident #69's MAR for the month of October showed the resident did receive antipsychotic and antidepressant medication daily. A review of Pharmacy Medication Regimen Reviews were not available for the months of July, August, September, October, or November. There were Pharmacy notes dated 8/3/2024, 9/11/2024, 9/24/2024, and 11/6/2024 with no recommendations or GDR attempts due to the	F 842	including agency staff. 4)The Director of Nursing/Designee will audit the Monthly Medication Reviews (MMRs) with physician recommendations, monthly for 3 months to ensure the records are uploaded to each individual residents electronic medical records as indicated. The Director of Nursing or designee will be responsible for reporting the results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of the audits.	

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use of antipsychotic medication.

A telephone interview was conducted on 11:19 AM at 3:36 PM with the Nurse Practitioner (NP). During the interview the NP stated anytime there was a pharmacy recommendation or MRR it was printed off by someone at the facility and placed in her book for review. The NP explained she did not always notice the date when the forms were completed by the pharmacy, but if a MRR had been signed by her then it should be scanned into the system.

A telephone interview was completed on 11/25/2024 at 1:12 PM with the Consultant Pharmacist. During the interview the Pharmacist reported the Medication Regimen Reviews were sent to the Director of Nursing (DON), Administrator, and the Corporate Nurse monthly. The Pharmacist said the MMRs needed to be completed monthly. The Pharmacist also explained that the former DON was receiving the reports and passing them along to the physicians, but due to all of the changes including the changes in ownership and in the computer system the facility was using she was not sure why the MMR were not in the system, but they should have been. She did indicate there were notes in the system that showed the medications had been reviewed. The Pharmacist went on to say the physician did not need to sign off on any pharmacy notes unless a recommendation was made.

An interview was completed on 11/27/2024 at 9:30 AM with the DON where she indicated if there were pharmacy recommendations then the facility would get them monthly. The DON explained once she received the MRR she would

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F 842	Continued From page 135 give them to the nurse manager and then they would go to the physician. If there were no recommendations, then there would be no form so therefore there may not be a form for each person each month. A MRR was only written if a medication was changed.	F 842		