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	345315	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF LUMBERTON	1170 LINKHAW ROAD LUMBERTON, NC 28358

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E 000	Initial Comments A recertification survey was conducted from 11/18/24 through 11/21/24. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # 8NLR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted at this facility from 11/18/24 through 11/21/24. Event ID #8NLR11. The following intakes were investigated: NC00221898, NC00221985, NC00220807, NC00217657, and NC00217009 1 of the 9 complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		12/19/24

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

Electronically Signed | 12/19/2024

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F 600	Continued From page 1 Based on record review, observation, and staff interviews, the facility failed to protect a resident's right to be free from resident to resident physical abuse for 2 of 4 residents reviewed for abuse (Resident #35 and Resident #78). On 08/28/24 Resident #35 attempted to grab belongings out of Resident #84's hat, Resident #84 told him to stop but he continued. In response, Resident #84 grabbed Resident #35 by the arm and shook him causing Resident #35 to fall to the floor. Resident #84 then attempted to run Resident #35 over with his wheelchair. Resident #35 was not injured. On 09/23/24 Resident #78 entered Resident #76's room and Resident #76 slapped Resident #78 on the left cheek with an open hand and Resident #78 sustained mild redness to her left cheek which resolved within minutes after being assessed. Findings included: 1. Resident #35 was admitted to the facility on 01/31/23 with diagnoses that included, anxiety disorder, cognitive communication deficit, lack of coordination, and unsteadiness on his feet. Review of a quarterly MDS assessment dated 08/12/24 revealed Resident #35 had severely impaired cognition. He had no moods or behaviors during the assessment look back period. Review of a care plan for Resident #35 (initiated on 02/26/23) documented the focus area of a behavior problem related to wandering into other resident's rooms and removing their personal items such as stuffed animals and toys thinking they belong to him. The goal was for Resident #35 to have fewer episodes by the review date.	F 600	F600 Free from Abuse and Neglect 1. Resident #35 and Resident #78 were both affected by inappropriate actions of Residents #84 and #76. Both residents #35 and #78 were removed from the presence of Resident #84 and #76 without being harmed. Both are safe and do not recall the incidents. Resident #84 was discharged from the facility on 8/28/2024. 2. All facility residents have the potential to be affected by inappropriate actions of other residents. 100% audit of all resident altercations for past 6 months (via facility risk management documentation) was completed on 12/12/2024 by LNHA. No other incidents were identified, and all reporting was managed correctly. 3. On 12/11/2024, abuse prevention and reporting in services were initiated by the Director of Nursing for all facility staff. The facility policies and federal and state prevention and reporting requirements were reviewed. Education was completed on 12/17/2024. All staff members will be required to receive the training prior to working in the facility. The DON will ensure that in servicing is completed on 100% of staff members. Ad-HOC QAPI was completed by LNHA with IDT members on 12/11/2024. Angel rounds were implemented on 12/16/2024 and senior staff members are rounding daily to ensure that staff members are aware of all incidents that could be related to abuse and neglect have been identified and reported appropriately. All residents will be protected and free from abuse. 4. The Director of Nursing and/or	

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F 600	Continued From page 2 Interventions included anticipation of his needs and to praise any indication of the resident's progress or improvement in behavior. Resident #84 was admitted to the facility on 03/15/24 with diagnoses that included schizoaffective bipolar type disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated 06/19/24 revealed Resident #84 had moderately impaired cognition. He had displayed physical and verbal behavioral symptoms directed toward others on 1 to 3 days during the assessment look back period. He used a wheelchair for mobility. A progress note written by the Unit Manager on 08/27/24 at 10:22 AM documented that Resident #84 was noted to have behaviors. He became upset and was threatening other residents. He cursed at another resident threatening him with a plastic straw. The Nurse Practitioner (NP) was called. A new order was received to increase Seroquel (antipsychotic medication) and to send to the hospital for evaluation. In an interview with the Unit Manager on 11/19/24 at 4:13 PM she stated she did not see what happened regarding Resident #84 on 08/27/24. A staff member (she could not remember who) told her Resident #84 was having behaviors in the hallway. She explained she did not know who any of the other residents were but knew that there had been no physical contact between residents. She reported she called the NP and received an order to increase Resident #84's Seroquel medication and to send him to the hospital for evaluation. She added it was her practice to call the NP when a resident began to have behaviors	F 600	designee will review facility angel rounds related to resident-to-resident abuse daily for five days, weekly for four weeks, and monthly for three months and/or until QAPI team deems compliance. The Director of Nursing, and/or designee, will review facility nurses notes and incident reports daily in the daily clinical meeting to ensure appropriate follow up and implementation of plans to prevent and protect residents from abuse. This will be monitored daily for 5 days, weekly for four weeks, and monthly for three months and/or until QAPI team deems compliance.	

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instead of waiting for the NP to do rounds so that a further increase in behaviors could be avoided. She stated that because there had been no contact between residents there was no abuse issue, and she did not notify the Administrator.

An interview was conducted with the NP on 11/20/24 at 2:21 PM. She stated he was familiar with Resident #84. She recalled she had been contacted on 08/27/24 because the resident was in a "rage", and she had increased his antipsychotic medication (Seroquel) at that time.

The care plan for Resident #84 dated 08/27/24 documented the following focal area: Resident #84 has a behavior problem related to a diagnosis of schizoaffective disorder and a history of intracranial injury with loss of consciousness. On 08/11/24 the resident washed and dried a sanitizer wipe container to use for drinking and refused to use a water pitcher, on 08/23/24 the resident cursed at housekeeping and threw a trash can, and on 08/27/24 the resident threatened others, ran into another resident's wheelchair, cursed at another resident while pointing a plastic straw in a threatening/stabbing motion. The resident was sent to the hospital for assessment. The goal was for Resident #84 to have fewer episodes by the next review date. Interventions included an increase in the dosage of his antipsychotic medication, administer medications as ordered and monitor for side effects, anticipate and meet his needs, intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from the situation and take to an alternate location, and a psychological evaluation as needed.

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An interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 11/19/24 at 3:50 PM. The DON stated he had not been aware that any incident involving Resident #84 had occurred on 08/27/24 until today. The ADON stated she had only heard about it. She was aware his antipsychotic medication had been increased and no further action had been taken.

An interview was conducted on 11/20/24 at 3:05 PM with the Case Manager at the hospital who cared for Resident #84 on 08/27/24. She stated on 08/27/24 Resident #84 presented at the emergency room for assessment related to a verbal altercation. She reported that Resident #84 was assessed as safe for discharge by the psychiatric team and the medical physician. He returned to the nursing home on 08/27/24.

A progress note written in the medical record of Resident #35 by the Assistant Director of Nursing (ADON) on 08/28/24 at 3:16 PM documented she had heard a resident yelling for help in the dining room. She entered the dining room and noted Resident #35 was on the floor and Resident #84 in from of Resident #35 in his wheelchair trying to run Resident #35 over with his wheelchair. Resident #35 was yelling out for help. The residents were separated and Resident #35 was assessed by the nurse and the NP. No new injuries were observed. Other residents in the dining room for the activity reported Resident #84 pushed Resident #35 to the ground.

A progress note written in the medical record of Resident #84 by the ADON on 08/28/24 at 3:47 PM documented that she had heard yelling from the dining room and noted Resident #84 in his

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wheelchair over Resident #35 attempting to run him over. Resident #84 was yelling that Resident #35 took his money. The residents were separated. An order was received to send Resident #84 to the hospital for evaluation.

The Initial Allegation Report dated 08/28/24 documented an allegation of resident abuse. Resident #84 was noted to have pushed Resident #35 to the floor while participating in group activities in the dining hall. The incident was witnessed by other residents and staff. Both residents were immediately separated and Resident #35 was assessed. No injuries were noted to Resident #35. The provider was notified and an order was received to send Resident #84 to the hospital for evaluation. Emergency medical services (EMS) and police were dispatched. Resident #35 complained of right ankle pain and range of motion to the right ankle was at baseline. Pharmacological intervention was initiated by the primary nurse. No mental anguish was noted.

A witness statement written by the DON documented he had been sitting in the conference room on 08/28/24 when he heard a resident yell. He immediately got up and went into the dining room to see Resident #35 sitting on the ground. Resident #84 shouted, "He tried to take my hat, and it has my money in it." Resident #35 was assessed and got off the floor into a chair. Resident #84 was immediately removed from the dining room and taken to the front lobby with one to one (1:1) supervision. The medical director, attending physician, and NP were all notified. Order were given to send Resident #84 to the emergency department for psychiatric evaluation related to combative behaviors. Resident #35 was taken to the DON office and interviewed

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regarding the altercation. Resident #35 stated, "He pushed me down. I don't hurt." Resident #35's skin was assessed by the primary nurse and DON and no injuries were noted. The statement was signed by the DON but was not dated.

An interview was conducted with the ADON on 11/19/24 at 1:07 PM. She stated Resident #84 was involved in a resident to resident altercation over money (08/28/24). She explained when she arrived at the dining hall Resident #84 was in his wheelchair leaning over Resident #35 who was on the ground. Resident #84 was trying to run over Resident #35 with his wheelchair. Resident #84 said, "Don't take my money!" She stated she separated the residents. She told the Unit Manager to call the NP who gave the facility an order to send Resident #84 to the hospital for an assessment.

The following interview between the ADON and Resident #53 was documented by the ADON. She documented that she had spoken with Resident #53 regarding the incident that occurred between Resident #84 and Resident #35. The ADON wrote that Resident #53 told her Resident #35 passed Resident #84 in the dining room. Resident #84 had his hat sitting on the table with belongings in it. When Resident #35 passed the table he attempted to grab the belongings out of Resident #84's hat. Resident #84 told Resident #35 several times not to but Resident #35 continued to grab his things. Resident #84 then stated, "I'm going to get you, I'm going to get you." Then Resident #84 proceeded to grab Resident #35 by his arm and shake him, causing him to fall to the ground. This undated statement was signed by the ADON and Resident #53.

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Record review of a quarterly MDS assessment dated 08/04/24 revealed Resident #53 had intact cognition.

The ADON documented an interview she conducted with Resident #33. The written statement is not dated. She documented she had spoken with Resident # 33 about the incident that happened between Resident #84 and Resident #35. Resident #33 told her he saw Resident #84 grab Resident #35 by his arm and Resident #35 fell to the floor. Resident #33 told the ADON he did not see Resident #35 take anything from Resident #84. This statement was signed by the ADON only. Record review of a quarterly MDS assessment dated 06/07/24 revealed Resident #33 had intact cognition.

The Investigation Report dated 08/30/24 completed by the DON related to the 08/28/24 allegation of resident abuse involving Resident #84 and Resident #35 was substantiated.

Resident #84 was no longer a resident at the facility and was not available for interview.

An interview was conducted with the Director of Nursing (DON) on 11/19/24 at 1:58 PM. He stated he was present when the resident to resident altercation occurred on 08/28/24 with Resident #84 and Resident #35. He reported that he had been in the conference room when he heard a resident yelling from the dining hall. When he arrived Resident #35 was on the floor and Resident #84 was over him. He took Resident #84 to the front lobby with 1:1 supervision until the ambulance arrived to take him to the hospital for assessment. He helped the ADON do a skin assessment on Resident #35 and started an

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initial report of abuse.

An interview was conducted with the interim Administrator on 11/19/24 at 12:44 PM. He stated that Resident #84 had a history of resisting care, and cursing at and throwing things at staff. He explained the staff were scared of him. He stated since Resident #84 went to the hospital and did not return he expected the other residents and staff would be safe.

2) Resident #76 was admitted to the facility on 06/05/24. Diagnoses included dementia and cognitive communication deficit.

The Minimum Data Set (MDS) quarterly assessment dated 09/12/24 revealed Resident #76 was severely cognitively impaired, had no functional limitations in range of motion and required no mobility device. She demonstrated no behaviors during this look back period and required supervision with one staff physical assistance with bed mobility and was independent with transfers.

The care plan for Resident #76's active care plan as of 9/22/24 did not include any information related to physical behaviors.

Resident #78 was admitted to the facility on 06/25/24. Diagnoses included Alzheimer's, dementia, cognitive communication deficit, and metabolic encephalopathy (condition in which brain function is disturbed either temporarily or permanently).

The MDS dated 07/02/24 5 day assessment revealed Resident #78 was severely cognitively impaired and demonstrated wandering behavior

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for 4 to 6 days during this assessment. She had no functional limitations with range of motion and required no mobility device and limited assistance with one staff physical assistance with bed mobility and was independent with transfers.

The care plan for Resident #78 initiated on 07/03/24 revealed a plan of care was in place for an elopement risk/wanderer related to impaired cognition and safety awareness, new environment and disorientation to place, and independently able to ambulate with a goal that the resident's safety will be maintained through the review date. Interventions included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, and books; frequently monitor resident's location; document wandering behavior and attempted diversional interventions as needed; and identify pattern of wandering. A plan of care initiated on 07/09/24 was also in place for potential behavior problem related to a history of metabolic encephalopathy and dementia with agitation with a goal that the resident would have no evidence of behavior problems by review date. Interventions included administering medications as ordered; monitor/document for side effects and effectiveness; anticipate and meet the resident's needs; and intervene as necessary to protect the rights and safety of others.

The initial allegation report dated 09/23/24 completed by the Administrator documented that Resident #78 entered into Resident #76's room. Resident #76 saw Resident #78 enter her room and slapped her (Resident #78) on the left cheek with an open hand. Both residents were immediately separated and Resident #76 was placed on one to one (1:1) observation. Resident

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#78 was noted to have no injury and denied pain.

A handwritten witness statement dated 09/23/24 by Medication Aide (MA) #3 revealed MA #3 was walking on the 500 hall when she saw Resident #78 walking out of Resident #76's room. She heard Resident #76 fussing and asked Resident #78 what was going on. Resident #78 stated she had to get Resident #76 together because she was in "my house." Resident #78 stated "yeah, she hit my side of the head." Resident #76 stated "I sure did and would do the same if somebody was in your house, too."

An interview was conducted with MA #3 via phone on 11/20/24 at 2:15 PM. MA #3 reported she did not witness Resident #76 hitting Resident #78. MA #4 stated she had heard Resident #76 yelling about Resident #78 being in her room and she asked Resident #78 what had happened. MA #3 stated Resident #78 told her Resident #76 hit her on the side of her face. MA #3 stated Resident #78 had some mild redness to her left cheek. MA #3 stated she asked Resident #76 if she hit Resident #78 and Resident #76 stated she did because Resident #78 came into her "house." MA #3 stated both residents appeared to be calm after the event and both residents were separated. MA #3 stated Resident #76 was placed on a one to one (1:1) where one staff observed her continuously to ensure the safety of the other residents. MA #3 stated she had not seen Resident #76 hit any resident prior to this event. MA #3 stated Resident #78 wandered around the facility freely and at times she would get confused as to where her room was. MA #3 stated she believed Resident #78 thought that Resident #76's room was hers. MA #3 stated Resident #78 would not stay in the other rooms or

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go through the person's belongings and that once she realized she was in the wrong room, she would leave. MA #3 stated she notified the Director of Nursing of what happened.

A Psychiatry Progress Note for Resident #76 written by Nurse Practitioner (NP) #1 on 09/23/24 revealed Resident #76 presented with an episode of physical aggression towards another resident (Resident #78) which was a behavioral disturbance consistent with her Dementia diagnosis. Staff reports indicated that the resident was easily agitated and can be aggressive further supporting the diagnosis. The resident's cognitive impairment was evident during the telehealth visit as she was unable to recall the incident or the name of the facility where she resided. The plan was to initiate Depakote for mood stability to manage the resident's behavioral disturbance associated with dementia. The medication should help to reduce the resident's agitation and aggressive behavior. A follow up in-person visit was planned for 09/27/24 to further evaluate the resident's condition. The resident's need for a one on one was discussed and deemed unnecessary at that time.

A Psychiatry Progress note written for Resident #78 by NP #1 dated 09/23/24 revealed, in part, Resident #78 experienced an altercation at the facility during which she was struck in the face. Examination revealed minor redness on the face which resolved quickly. There were no injuries noted and the resident did not report any pain or discomfort.

The summary of the investigation report dated 09/28/24 completed by the Administrator

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documented the allegation involving Resident #76 and Resident #78 was substantiated. The incident was not witnessed by a staff member. The incident was vocalized to staff by both Resident #78 and Resident #76. Both residents were immediately separated. Resident #78 was assessed and noted with mild redness to the left side of her face which resolved after a few minutes. Resident #78 denied pain.

An observation of Resident #76 was conducted on 11/18/24. Resident #76 was in her room with the door closed. She was pleasant but not oriented to time or place. Resident #76 had no recollection of any resident coming into her room.

Observations of Resident #78 were conducted daily throughout the survey on 11/18/24 at 1:30 PM and 4:00 PM, on 11/19/24 at 9:00 AM, 10:00 AM, 11:00 AM, and 3:30 PM, on 11/20/24 at 9:30 AM, 10:45 AM, 11:35 AM, and 3:10 PM, and on 11/21/24 at 8:30 AM, 9:15 AM, 11:20 AM, and 1:10 PM. Resident #78 was alert but not oriented to time or place. Resident #78 was noted to be sitting in the common area during these times. She was not noted to be wandering in other rooms.

An interview was conducted with the Social Worker (SW) on 11/20/24 at 2:30 PM. The SW stated after the event between Resident #76 and Resident #78 occurred on 09/23/24, Resident #78 was on frequent monitoring to ensure she was not wandering into other resident's rooms. The SW stated it was an isolated event and she had not seen Resident #76 hit any other residents before.

An interview was conducted with the Director of

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F 600	Continued From page 13 Nursing (DON) on 11/20/24 at 3:30 PM. The DON reported he was made aware of Resident #76 slapping Resident #78 in the face by MA # on 09/23/24 at 1:00 PM. He stated Resident #78 wandered throughout the facility and often sat in the common area which was close to Resident #76's room. He stated Resident #78 was confused and from time to time, not very often, she would accidentally go into other residents' rooms thinking it was her room. The DON stated he assessed Resident #78 after the incident and she had some mild redness to her left cheek which resolved quickly. The DON stated he felt it was an isolated incident between Resident #76 and Resident #78.	F 600		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of	F 626		12/19/24

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F 626	Continued From page 14 returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, and Resident Representative (RR), Hospital Case Manager, Psychiatric Provider, and staff interviews, the facility failed to permit a resident to return to the facility after being transferred to the hospital for evaluation due to a resident to resident altercation for 1 of 1 resident reviewed for hospitalization (Resident #84). The findings included: Resident #84 was admitted to the facility 3/15/24 with diagnoses that included schizoaffective disorder, bipolar type and unspecified intracranial injury. Review of the facility Action Summary Report revealed Resident #84 had been discharged/transferred to another hospital on 08/28/24. Review of a quarterly Minimum Data Set	F 626	F626 Permitting residents to return to the facility 1. Resident #84 discharged to the hospital on 8/28/2024. 2. All facility residents that are discharged to the hospital will be allowed to return to the facility.100% audit, of all facility discharges for past 30 days, was completed on 12/13/2024 by LNHA. There were no additional incidents. On 12/19/2024 LNHA spoke to Neice-in-Law of Resident#84. Neice-in-Law stated resident #84 discharged home from hospital in August. Neice-in-law states that resident is safe and needs are being met at home and resident has a primary care provider in community. LNHA let niece-in-law know that if they needed assistance with placement in the future to reach out and LNHA would be of assistance. On 12/20/2024 LNHA and COO spoke with	

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F 626	Continued From page 15 assessment dated 06/19/24 revealed Resident had moderately impaired cognition. He had physical and verbal behavioral symptoms directed towards other that occurred on 1 to 3 days. He used a wheelchair for mobility. He had a traumatic brain injury and schizophrenia. He had received antipsychotic and antidepressant medications during the assessment look back period. A progress note written by the Assistant Director of Nursing (ADON) on 08/28/24 at 3:47 PM documented that she had heard yelling from the dining room and noted Resident #84 in his wheelchair over Resident #35 attempting to run him over. Resident #84 was yelling that Resident #35 took his money. The residents were separated. The psychiatric provider and the RR were notified. An order was received to send Resident #84 to the hospital for evaluation. An interview was conducted with the ADON on 11/19/24 at 1:07 PM. She stated Resident #84 was involved in a resident to resident altercation over money. She recalled she had instructed the Unit Manager to call the provider and get an order to send Resident #84 to the hospital for evaluation. She stated she did not remember telling the hospital Case Manager that Resident #84 could not return to the facility because he was a danger to the other residents, but that it was so long ago that she may have. She noted that no order had been entered into the electronic medical record to send Resident #84 to the hospital or to refuse to readmit the resident on 08/28/24 because the Unit Manager had taken a verbal order from the provider and forgotten to write it. She stated she did not know that the facility had an obligation to take Resident #84	F 626	nephew of Resident #84 and offered readmission back to Carrolton of Lumberton. Nephew verbalized that resident #84 did not want to return to Carrolton of Lumberton. 3. On 12/11/2024, In-service was initiated by the Director of Nursing with all licensed nurses, Social Worker, and IDT members on facility policy of residents readmitting and permitted to return. All education was completed by 12/17/2024. After 12/17/2024, any staff members that have not worked will receive the in-services upon the next scheduled shift. On 12/12/2024, LNHA educated ADON on facility policy for residents readmitting and requirement to permit re-entry to the facility. Ad-HOC QAPI was completed by LNHA with IDT members on 12/11/2024. On 12/13/2024, LNHA emailed a statement to the COO of UNC-Southeastern (main hospital for facility) for hospital to notify LNHA if facility failed to follow facility policy related to readmission of residents. All patients will be allowed readmission. 4. The Social Worker and/or designee will monitor all facility discharges related to return to facility after residents are either hospitalized or placed on therapeutic leave per facility policy. Social Worker and/or designee will monitor all facility discharges daily for five days, weekly for four weeks, and monthly for three months and/or until QAPI team deems compliance	

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back once he was assessed to be a safe discharge from the hospital. She thought the facility had the right to deny his readmission. She also thought the psychiatric provider had given an order to the Unit Manager to not take the resident back but had not spoken to the psychiatric provider herself. The resident was not readmitted to the nursing home.

An interview was conducted with the Psychiatric provider on 11/20/24 at 2:21 PM. She stated he was familiar with Resident #84. She recalled she had been contacted on 08/27/24 because the resident was in a "rage", and she had increased his antipsychotic medication (Seroquel) at that time. On 08/28/24 she gave an order to send the Resident #84 back to the hospital for evaluation due to his involvement in a resident to resident altercation. She stated that was the only order she gave. She did not speak to the hospital on 08/28/24 and did not give an order for Resident #84 not to return to the facility. She noted it was the responsibility of the facility to take the resident back once deem to no longer be a threat. She stated she had consulted with her supervising physician who agreed with the increase in the medication Seroquel and explained it would take time for the increase in the medication to be effective and change the resident's behavior. She stated the facility could have made adjustments to take the resident back.

An interview was conducted on 11/20/24 at 3:05 PM with the hospital Case Manager who cared for Resident #84 on 08/28/24. She stated she had cared for Resident #84 on 08/27/24 also when he presented to the hospital after a verbal altercation at the facility. On 08/27/24 he was cleared by psychiatry to return to the facility which he did. On

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08/28/24 Resident #84 presented again at the hospital for assessment. She spoke with the ADON at the facility who informed her Resident #84 could not return to the facility because he pushed a resident and assaulted staff. The hospital Case Manager explained to the facility that Resident #84 had been evaluated by the psychiatry team and the medical physician and was assessed as safe to return to the facility. She told the ADON that the hospital was not a drop off destination and was not part of a facility discharge plan, but the ADON refused to take the resident back. The hospital Case Manager stated she contacted a family member who picked the resident up from the hospital and took him home. She stated the family member was in disbelief that the facility refused to take him back.

A progress note written by the Social Worker at the facility on 09/12/24 at 2:49 PM documented that he had a meeting with the RR for Resident #84 and provided him with an FL2 form (a medical form that a doctor completes to describe a patient's medical condition and the level of care they need), order summary and NCTracks (a multi-payer Medicaid Management Information System for the North Carolina Department of Health and Human Services) Approved FL2 in case the family needed the forms to place the resident elsewhere.

An interview was conducted with the facility Social Worker on 11/21/24 at 9:49 AM. He stated the RR of Resident #84 came to the facility seeking documentation to place the resident at another facility. He explained that the resident had gone to the hospital for evaluation and normally would return once cleared by the hospital physician as not a danger, but Resident #84 did not return. He

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concluded once the resident left the facility he was no longer involved with his care except for when the RR requested documents to place the resident elsewhere.

An interview was conducted with the RR on 11/21/24 at 12:33 PM. He stated he was not prepared to care for Resident #84 at his home. He explained the hospital had contracted him on 08/28/24 and asked him to pick up the resident because the nursing home would not take him back and that he was ready for discharge. He stated he was able to set up a room and make accommodations for Resident #84's wheelchair in his home. The RR reported Resident #84 had not received his checks since he left the facility, and the RR had gone through all his savings in an effort to care for Resident #84 and provide basic needs such as food. He stated he did not have any help and was providing all of Resident #84's care himself. He explained he was working with a doctor to find placement for Resident #84 but that so far two other facilities had denied him admission based on a history of violent behaviors.

An interview was conducted with the Director of Nursing (DON) on 11/19/24 at 1:58 PM. He stated he was present when the resident to resident altercation occurred with Resident #84. He reported that Resident #84 was taken to the front lobby with 1:1 supervision until the ambulance arrived to take him to the hospital for assessment. He noted the facility had an obligation to hold his bed for 30 days after a discharge to the hospital. He stated he was aware that the facility could not refuse to take the resident back after he was cleared by the hospital as a safe discharge. He was not aware the

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F 626	Continued From page 19 hospital had been told the resident could not return. He stated he knew the resident had gone home with a family member. An interview was conducted with the Administrator on 11/19/24 at 12:44 PM. He stated he had not been involved with the case because the DON had filed all the reports to the State. He noted that he was not aware the ADON had refused to take the resident back. He thought it was a judgement call by the ADON at the time because staff feared Resident #84 who hollered and cursed them. He stated he was aware it was the facility's obligation to take Resident #84 back when he was evaluated as safe for discharge by the hospital.	F 626		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Consulting Pharmacist, Nurse Practitioner and staff interviews, the facility failed to a) clarify a physician's order for 26 days to determine the right dose to be administered for a daily topical medication to manage pain related to osteoarthritis (degeneration of bone that can cause pain) for Resident #60, b) follow the physician's orders to remove a lidocaine patch (medicated topical pain patch) after 12 hours of use to prevent potential skin irritation, redness, swelling, and/or discomfort for Resident #67 and	F 658	F 658 Services Provided Meet Professional Standards Immediate action(s) taken for the resident(s) found to have been affected include: The physician□s order for Resident #60 was clarified and corrected immediately upon surveyor notification on 11/20/2024 by the Unit Manager to include the medication□s dose. The lidocaine patch for Resident #67 was	12/19/24

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F 658	Continued From page 20 c) to administer the correct ordered dose of a supplemental medication three times for Resident #18. This was for 3 of 3 residents sampled for medication review. Findings included: 1a. Resident #60 was admitted to the facility on 08/30/24. Diagnoses included Dementia and osteoarthritis (type of degenerative joint disease). The Minimum Data Set (MDS) admission assessment dated 09/06/24 revealed Resident #60 was severely cognitively impaired. A physician order written on 10/24/24 revealed an order for Diclofenac Sodium External 1% (an anti-inflammatory ointment used to treat pain) apply to left hand topically (on top of skin) three times daily for osteoarthritis. The order did not indicate the dose (# of grams) to be applied. Review of the October Medication Administration Record revealed Diclofenac Sodium External 1% apply to left hand topically three times daily, but did not indicate the dose (# of grams) to be applied. The medication was being applied three times daily as evidenced by nursing initials and check marks on the MAR from 10/24/24 through 10/31/24 for a total of 24 doses. Review of the November Medication Administration Record revealed Diclofenac Sodium External 1% apply to left hand topically three times daily, but did not indicate the dose (# of grams) to be applied. The medication was being applied three times daily as evidenced by nursing initials and check marks on the MAR from 11/01/24 through 11/19/24 for a total of 57	F 658	removed immediately by Medication Aide #1 after identification on 11/19/2024. The stock medication for Resident # 18, Vitamin D3 125 micrograms/5000 units, was replaced on the medication cart immediately after the surveyor notified us by the unit manager on 11/20/2024. Identification of other residents having the potential to be affected was accomplished by: All facility residents receiving medications have the potential to be affected. On 12/12/24, the Director of Nursing (DON) completed a 100% audit of all residents with lidocaine patches. On 12/12/2024, the DON completed a 100% audit of all five facility medication carts for stock medications, including Vitamin D3 125 micrograms/5000 units. Actions taken/systems put into place to reduce the risk of future occurrence include: From 12/11/2024 through 12/17/24, the DON initiated in-services with all licensed nursing staff and certified medication aides related to performing jobs to professional standards, including proper medication administration. Licensed nursing staff and medication aides who have not received the in-services will be educated upon their next scheduled shift. The licensed nursing home administrator	

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F 658	Continued From page 21 doses. A medication pass observation was conducted with Nurse #7 on 11/20/24 at 9:15 AM. Nurse #7 reviewed Resident #60's orders and noted he was to receive Diclofenac Sodium External 1% ointment to apply to his left hand. She was unable to locate Diclofenac Sodium External 1% for Resident #60. At this time, Nurse #7 went to the medication storage room to obtain a "house stock" of the Diclofenac 1% ointment. Upon return to the medication cart, Nurse #7 proceeded to apply the Diclofenac 1% ointment, but realized the order did not indicate the dose to be applied. Nurse #7 asked the Unit Manager to get the order clarified. The order was then rewritten to apply Diclofenac Sodium External 1% apply 2 grams to left hand topically three times daily for osteoarthritis. Nurse #7 applied the ordered 2 grams of the Diclofenac 1% ointment to Resident #60's left hand. An interview was conducted with Nurse #7 on 11/20/24 at 9:30 AM. Nurse #7 revealed she did not realize the order for the Diclofenac 1% ointment did not have a dose indicated on the order but she knew from other residents the usual dose was between 2 - 4 grams, and stated she could not say for certain how many grams she applied to Resident #60. Nurse #7 stated she should have clarified the order to ensure she was administering the appropriate dose. Nurse #7 confirmed she had administered the ointment 15 times since 10/24/24 through 11/19/24 and was not aware of the actual dose to be applied. An interview was conducted with Nurse #5 on 11/20/24 at 4:15 PM. Nurse #5 reviewed the order for Diclofenac 1% ointment for Resident	F 658	(LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON and/or designee will audit up to 5 resident records weekly for four weeks, then monthly for two months, to ensure medication orders are complete with all elements, including dosage. The DON and/or designee will audit up to 5 residents on a lidocaine patch weekly for four weeks to ensure proper removal is completed as ordered and then monthly for three months. The DON and/or designee will audit all facility medication carts once weekly for four weeks to ensure that all ordered stock medications are available on each cart. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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#60 and confirmed there was no dose on the order to know how much to apply. Nurse #5 stated she would squeeze some (not specific amount) on the measuring strip that was provided in the box and then apply it. Nurse #5 stated she administered the ointment 18 times since 10/24/24 through 11/19/24 and she should have clarified the order before applying the ointment.

An interview was conducted with Medication Aide #2 on 11/20/24 at 1:00 PM. MA #2 stated the order did not say how much to apply so she just put a small amount on Resident #60 and she did not measure the amount. MA #2 stated she should have reported to the nurse that the order did not indicate a dose and it should have been clarified. MA #2 confirmed she applied the Diclofenac 1% ointment to Resident #60 6 times since 11/01/24.

An interview was conducted Medication Aide #3 via phone on 11/20/20 at 1:22 PM. MA #3 confirmed she applied the Diclofenac 1% ointment 8 times since 10/24/24 through 11/19/24 and stated she would just put some in a cup and then apply it to Resident #60, but she did not measure it. MA #3 stated she should have reported to her nurse that the order needed to be clarified to be sure to apply the correct dose.

An interview was conducted with Medication Aide #4 on 11/20/20 at 1:30 PM. MA #4 reported she would apply a small amount Diclofenac 1% on the measuring strip that was provided, but she did not know how many grams she applied. MA #4 confirmed she applied the ointment one time on 11/02/24.

An interview was conducted with Nurse #6 on

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11/21/24 at 10:22 AM. Nurse #6 reported that she did not usually work on that unit but confirmed she had applied the Diclofenac 1% on 11/13/24 to Resident #60 without knowing the actual number of grams to be applied. Nurse #6 stated she should have clarified this order for the actual dose to be applied.

An interview was conducted with the Consulting Pharmacist via phone on 11/21/24 at 3:27 PM. The Pharmacist reviewed the order for Resident #60 for the Diclofenac 1% and stated the order should have indicated the dose amount to be applied. The Pharmacist stated she would have expected the order to be clarified back when it was put in on 10/24/24 and added that receiving too much of the Diclofenac 1% ointment would inhibit the absorption of the ointment and receiving too little of the ointment by not having it evenly spread throughout his hand, the resident may exhibit unrelieved pain. The Pharmacist added the last time she completed her monthly drug regimen review for this resident was on 10/09/24.

An interview was conducted with the Director of Nursing (DON) on 11/21/24 at 3:30 PM. The DON stated he would have expected the order for the Diclofenac 1% to be clarified when the order was first initiated on 10/24/24. The DON added that the nursing staff should always utilize the 5 rights of drug administration whenever they are administering physician order medications which includes the right dose.

1b. Resident #67 was admitted to the facility on 02/20/24. Diagnoses included pain.

The MDS annual assessment dated 11/06/24

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revealed Resident #67 was cognitively intact and was on a pain medication regimen for occasional moderate pain.

A physician's order was written on 02/24/24 for Lidocaine external patch 4%, apply to back topically one time a day for pain. Remove after 12 hours.

Review of the November 2024 Medication Administration Record (MAR) revealed the Lidocaine external patch 4% was signed off as being removed by Nurse #5 on 11/19/24 at 9:00 PM.

During a medication pass with Medication Aide (MA) #1 on 11/20/24 at 8:30 AM, MA #1 revealed she was going to apply a Lidocaine Patch 4% to Resident #67's back. Prior to applying the patch, MA #1 noted the existing patch on Resident #67's back was dated 11/19/24. MA #1 stated, "the nurse left your patch on last night," and she then removed the existing patch. There was no redness or skin irritation noted. MA #1 applied the new patch to Resident #67's back.

An interview with Nurse #5 on 11/20/24 at 4:14 PM revealed she should not have signed off on the MAR that she removed the Lidocaine patch when she did not. Nurse #5 stated she was quickly signing off her medications to be administered and had signed off the removal of the Lidocaine patch before she was supposed to remove the patch and then forgot to remove the patch because she got busy.

An interview with the Nurse Practitioner (NP) on 11/21/24 at 2:40 PM via phone revealed she would have expected the Lidocaine Patch to be

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removed after 12 hours as ordered. The NP stated wearing lidocaine patches for more than 12 hours can cause skin irritation, redness, swelling, and discomfort. The NP stated if there was no irritation noted it would be okay for MA #1 to apply the new patch as ordered.

An interview was conducted with the Director of Nursing on 11/21/24 at 3:30 PM. The DON stated he would have expected his nursing staff to remove the Lidocaine Patch as ordered.

1c. Resident #18 had a physician's order written on 11/15/24 for Vitamin D3 125 micrograms (mcg) 5000 units one tablet by mouth once daily.

A medication pass observation was conducted on 11/20/24 at 8:30 AM with Medication Aide #1 for Resident #18. MA #1 reviewed Resident #18's orders and noted he was to receive Vitamin D3 125 mcg/5,000 units one tablet daily. MA #1 checked her medication cart for this supplement and was noted to have a bottle of Vitamin D3 25 mcg/400 unit bottle only. MA #1 did not administer the Vitamin D3 25 mcg/400 unit dose.

An interview with Medication Aide #1 on 11/20/24 at 8:30 AM revealed the order for the Vitamin D3 125 mcg/5,000 units changed on 11/15/24 and they were waiting for it to arrive from the Pharmacy. MA #1 stated there was no order to give the Vitamin D3 25 mcg/400 unit tablet until the Vitamin D3 125 mcg/5000 unit tablets arrived. The MA stated there was no order to hold the Vitamin D3 125 mcg/5000 units until it was available. MA #1 stated she should have notified the Nurse that the medication was not available so that the Nurse could obtain an order to hold the Vitamin D3 125 mcg/5000 until it was

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available.

During reconciliation of the medication pass conducted with Medication Aide #1, a review of the November 2024 Medication Administration Record (MAR) revealed the medication to treat a Vitamin D deficiency, Vitamin D3 125 mcg 5000 units, was signed off as given by Medication Aide #5 on 11/16/24, MA #4 on 11/17/24 and MA #1 on 11/18/24 and 11/19/24.

An interview with MA #1 on 11/20/24 at 10:10 AM revealed she administered the Vitamin D3 25 mcg/400 units tablet on 11/18/24 and 11/19/24. She stated she misread the bottle of Vitamin D3 and thought it was 125 mcg but it was 25 mcg.

A phone interview with MA #4 on 11/20/24 at 1:00 PM revealed she administered the Vitamin D3 25 mcg/400 units tablet on 11/18/24 and 11/19/24. She stated she misread the bottle of Vitamin D3 and thought it was 125 mcg but it was 25 mcg.

A phone interview was attempted with MA #5 on 11/20/24 at 1:17 PM. MA #4 did not return call.

An interview was conducted with the Consulting Pharmacist via phone on 11/21/24 at 3:27 PM. The Pharmacist stated that not receiving the ordered dose but getting a lower than intended dose would not cause ill effects or harm. The Pharmacist stated, however, that she would have expected the Medication Aides to read the label carefully to ensure they was administering the ordered dose according to the 5 rights of drug administration (right patient, right drug, right dose, right route of administration, and right time).

An interview was conducted with the Director of

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F 658	Continued From page 27 Nursing on 11/21/24 at 3:30 PM. The DON stated it was the responsibility of the Medication Aides to read the labels carefully to make sure the right medication and the right dose was being administered and that they should have alerted the Nurse to notify the physician to hold the Vitamin D3 125 mcg/5000 units until it arrived.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		12/19/24

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F 690	Continued From page 28 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interview the facility failed to secure a resident's indwelling urinary catheter tubing to prevent tension or trauma for 1of 1 resident reviewed for urinary catheter (Resident #54). Findings included: Resident #54 was admitted to the facility on 12/14/22 with diagnoses that included pressure ulcer sacral region stage IV and dementia. The quarterly Minimum Data Set assessment dated 09/21/24 revealed Resident #54's cognition was moderately impaired, was incontinent of bowel and bladder, had a stage IV sacral pressure ulcer, and had an indwelling urinary catheter. Review of Resident #54's care plan revised 11/2024 addressed the use of an indwelling urinary catheter. Resident #54 had a stage IV pressure ulcer to her sacrum and potential for further pressure ulcer development and infections related to: mobility impairments, incontinent of bowel and bladder, diabetes, fragile skin integrity, and indwelling urinary catheter. A stage IV sacral pressure wound dressing observation was conducted on 11/20/24 at 9:20	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate action(s) taken for the resident(s) found to have been affected include: Upon surveyor notification on 11/20/24, a licensed nurse placed a catheter security strap on Resident #54 to prevent tension or trauma. Identification of other residents having the potential to be affected was accomplished by: All facility residents with urinary catheters have the potential to be affected. On 12/12/2024, the unit manager audited 100% of facility residents with indwelling catheters to ensure security straps were in place. Actions taken/systems put into place to reduce the risk of future occurrence include: 12/11/2024- 12/17/24, the Director of Nursing (DON) initiated in-services with all licensed nursing staff regarding catheter management per facility clinical procedure Catheter Care, Indwelling Cather. Licensed nursing staff who have not received the in-services will be educated	

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F 690	Continued From page 29 AM with the Wound Treatment Nurse. During the observation, Resident #54 was lying in bed with her urinary catheter tubing hanging off the right side of the bed without the tubing being secured, and the catheter bag was hooked to the lower right side of the bed. An interview was conducted on 11/20/24 at 9:30 AM with Resident #54. When the Resident was asked if the catheter tubing was secured to her leg to prevent pulling on the tubing she replied, "I asked my nurse for one, but never got it, and often I don't have one." An interview was conducted on 11/20/24 at 9:33 AM with the Wound Treatment Nurse. She said the resident's catheter tubing should have been secured by her nurse and was not. The Wound Nurse was observed to remove a new stat-lock (a catheter tubing stabilizing device) out of the top drawer of her treatment cart and secured resident's urinary tubing to her upper right thigh, which the resident thanked her for doing. An interview was conducted on 11/20/24 at 9:35 AM with Nurse #2. Nurse #2 stated residents with urinary catheter tubing do not have to have a stabilizing device on their catheter tubing, and stated Resident #54 did not want one. An interview was conducted on 11/20/24 at 9:38 AM with the Assistant Director of Nursing (ADON). She stated Resident #54 should have had her urinary catheter tubing secured to her thigh per facility policy, and did not. The ADON stated there should be a stabilizing device in place for every resident in the facility with an indwelling urinary catheter.	F 690	upon their next scheduled shift. The licensed nursing home administrator (LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON and/or designee will audit all facility residents with an indwelling catheter five times weekly for four weeks to ensure the leg strap is in place. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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F 690	Continued From page 30 An interview was conducted with the Administrator on 11/20/24 at 9:45 AM. The Administrator explained that every indwelling urinary catheter should have a stabilizing device in place to prevent trauma caused by pulling on the catheter tubing.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Dialysis Nurse and staff interviews, the facility failed to follow the physician's orders to remove a dressing to an arterial venous fistula (a surgically created connection between artery and vein in the arm used for dialysis treatments) one hour after dialysis treatment to monitor for bleeding at the access cite and to prevent potential damage to the access cite for 1 of 2 residents (Resident #69) reviewed for dialysis. Findings included: Resident #69 was admitted to the facility on 10/10/24. Diagnoses included, in part, end stage renal disease (ESRD) and dependent on dialysis. The MDS admission assessment dated 10/17/24 revealed Resident #69 was moderately cognitively impaired and was receiving dialysis services.	F 698	F698 Dialysis Immediate action(s) taken for the resident(s) found to have been affected include: The dressing on Resident # 69□s arterial venous fistula was removed on 11/20/24 by a licensed nurse after surveyor notification. Identification of other residents having the potential to be affected was accomplished by: All facility residents receiving dialysis services have the potential to be affected. On 11/22/24, the Director of Nursing (DON) completed a 100% audit of all facility residents receiving dialysis to ensure all arterial venous fistula dressings were removed post-dialysis treatment per physician orders.	12/19/24

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F 698	Continued From page 31 Resident #69's care plan dated 10/22/24 revealed a plan of care for requiring hemodialysis with a goal that resident would have no signs or symptoms of complications from dialysis through the review date. Interventions to include, in part, monitor/document/report as needed any signs or symptoms of infection to access site such as redness, swelling, warmth or drainage. A physician's order written on 10/11/24 revealed Resident to receive dialysis on Monday, Wednesday, and Friday. A dialysis communication sheet dated 10/20/24 written by the Dialysis Nurse revealed under other concerns a note indicating "please remove gauze dressing from dialysis site the night of dialysis. Leaving it on can damage the access." A physician's order was written on 11/01/24 to remove dressing to left arm dialysis access site approximately one hour after return from dialysis each evening shift on Monday, Wednesday, and Friday. Review of the November 2024 MAR revealed the order to remove the dressing to left arm dialysis access site was signed off as being removed by Nurse #5 on 11/20/24. An interview was conducted with Nurse #5 on 11/21/24 at 10:45 AM. Nurse #5 revealed there was no order to remove the dressing so she did not remove the dressing. Nurse #5 reviewed the physician orders and confirmed there was an order in the MAR to remove the dressing. Nurse #5 stated she did not usually remove the dressing from access sites and that the Medication Aide's	F 698	Actions taken/systems put into place to reduce the risk of future occurrence include: 12/11/2024- 12/17/24, the DON initiated in-services with all licensed nursing staff related to following post-dialysis physician orders, including removing dressings to arterial venous fistula sites. Licensed nursing staff who have not received the in-services will be educated upon their next scheduled shift. The licensed nursing home administrator (LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON and/or Designee will audit all facility residents receiving dialysis weekly for four weeks, then monthly for two months, to ensure dressings are removed as ordered by the physician following dialysis treatments. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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removed the dressings.

An observation of Resident #69 on Thursday, 11/21/24 at 9:30 AM, revealed Resident #69 was noted to have his dressing in place to his left arm access site.

An interview with Nurse Aide #4 on 11/21/24 at 9:30 AM revealed she was getting Resident #69 ready for his bed bath at this time and she was removing the dressing from Resident #69's left arm access site. She stated the dressing had been on since yesterday's dialysis treatment and she did not see any blood seeping through the dressing and felt it was safe to remove.

An interview was conducted with the Dialysis Nurse via phone on 11/21/24 at 2:55 PM. The Dialysis Nurse stated she notified the facility on 10/20/24 via a communication form to be sure to remove the dressing to the fistula site for Resident #69 the day of receiving the dialysis treatment. The Dialysis Nurse stated leaving the dressing on for extended period of time causes indents to the arterial venous fistula and makes it difficult to access the fistula in order to dialyze.

An interview was conducted with the Director of Nursing on 11/21/24 at 3:30 PM. The DON reported there had been a concern in the past that the dressing was not being removed the night of the dialysis treatment and he had addressed the concern with his nursing staff to ensure the dressing was removed after each dialysis treatment on Monday, Wednesday and Friday and had an order put in place on 11/01/24 to remind nursing staff to remove the dressing. He stated Nurse #5 should have been aware of the physician's order as it was part of Resident

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F 698	Continued From page 33 #69's medication administration record. The DON stated the dressing could be removed from nursing staff with the expectation that if there was any bleeding noted, the nursing staff such as Nurse Aides and Medication Aides would notify the licensed nurse in charge.	F 698		
F 727 SS=E	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 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 provide 8 consecutive hours of Registered Nurse (RN) coverage a day, 7 days a week for 13 of 139 days reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 2, 2024 (January 1-March 31, 2024) documented the facility had no RN coverage on 01/13/24, 01/20/24, 01/21/24, 02/03/24, 02/18/24, 02/24/24, 03/02/24, 03/24/24, and 03/30/24; and for Quarter	F 727	F727 RN 8 Hrs/7 days/Wk, Full Time DON Immediate action(s) taken for the resident(s) found to have been affected include: The facility reviewed the schedules for Registered Nurse (RN) coverage for the past three months. The facility leaders (Administrator and Director of Nursing) will ensure that the facility maintains adequate staffing, including RN coverage eight hours per day, seven days a week, excluding the	12/19/24

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F 727	Continued From page 34 3, 2024 (April 1-June 30, 2024) on 04/06/24, 04/28/24, 05/04/24, 05/11/24, 05/12/24, and 05/26/24. Review of the facility daily staffing documentation revealed the DON (Director of Nursing) had worked 8 consecutive hours as a staff nurse on 01/21/24 and 04/06/24 after he had fulfilled his full time DON obligation (40 hours) as the DON for both weeks. In an interview with the Administrator on 11/19/24 at 12:44 PM he stated the facility had hired an RN Weekend Supervisor and there had been no recent issues with RN coverage. He noted that on some of the days that there was no weekend RN coverage the DON had worked as a staff nurse to fill the need. In an interview with the Nursing Scheduler/Payroll Manager on 11/21/24 at 11:11 AM she confirmed there was no RN coverage in the building for 8 hours on the following dates: 01/13/24, 01/20/24, 02/03/24, 02/18/24, 02/24/24, 03/02/24, 03/24/24, 03/30/24, 04/28/24, 05/04/24, 05/11/24, 05/12/24, and 05/26/24. She reported that the facility did have RN coverage in the building for 12 consecutive hours on 01/21/24 and 04/06/24. She explained the DON had worked on the floor on 02/24/24 and 04/06/24 but because he was salaried and did not punch the time clock the hours were not reported on the PBJ report. She stated that on both days the DON worked as a staff nurse, he had already worked 40 hours as the full time DON. She noted that the problem on the weekends with staffing a Registered Nurse (RN) for 8 consecutive hours was because the weekend RN Supervisor that had been employed was not reliable. She stated the facility had hired	F 727	Director of Nursing (DON). An additional RN Supervisor was hired on 11/7/2024. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: The administrator, DON, and the scheduler will review staffing and assignments during the morning meeting daily to ensure adequate staffing for the next day. Sponsored ads have been placed for additional staff members to hire to ensure sufficient staffing is available. RN Supervisor for Baylor Weekends is currently employed at the facility. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator, DON, and Unit Manager will review schedules daily to ensure that the following 24-hour assignments include RN coverage 8 hours per day / 7 days per week. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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	345315	A. BUILDING _____ B. WING _____	C 11/21/2024

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F 727	Continued From page 35 a new RN Weekend Supervisor and there have not been any recent problems with staffing. In an interview with the DON on 11/21/24 at 11:00 AM he stated that on the two days he worked as a staff nurse, he had already worked 40 hours as the full time DON both weeks. He reported that the staffing problem had occurred because the RN Weekend Supervisor they had was not dependable. He noted the position had been filled and there had been no problems with RN coverage since.	F 727		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure it was free of medication error rates greater than 5% as evidenced by 2 medication errors out of 25 opportunities, resulting in a medication error rate of 8% for 1 of 3 residents (Resident #60) observed during medication administration preparation. Findings included: Resident #60 was admitted to the facility on 08/30/24. The Minimum Data Set (MDS) admission assessment dated 09/06/24 revealed Resident #60 was severely cognitively impaired.	F 759	F759 Medication Error Rate Greater than 5% (12%) Immediate action(s) taken for the resident(s) found to have been affected include: On 11/20/24, the Director of Nursing (DON) educated nurse #7 one-on-one about facility medication administration protocol. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be affected.	12/19/24

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F 759	Continued From page 36 On 11/20/24 at 9:15 AM a medication administration preparation was observed with Nurse #7 for Resident #60. Nurse #7 was observed preparing the following medications for administration: Allopurinol (a medication to treat gout) 100 milligrams (mg) one tablet, Ciprofloxacin (an antibiotic medication to treat infection) 500 mg (2 tablets), Finasteride (a medication to treat enlarged prostate) 5 mg one tablet, Haldol (a medication to treat psychosis) 5 mg one tablet, Protonix (a medication to treat reflux disease) 20 mg one tablet, Seroquel (a medication to treat depression) 25 mg one tablet, Flomax (a medication to treat enlarged prostate) 0.4 mg capsule and aspirin (a cardiac supplement) 81 mg one tablet. Nurse #7 was noted have put all the medications except for the Flomax in a medication dispensing cup. A review of the Ciprofloxacin medication dispensing card for Resident #60 revealed one tablet should be administered twice daily. Nurse #7 was observed putting two tablets in the dispensing cup. A review of the Protonix medication dispensing card for Resident #60 revealed a bright yellow sticker which read "do not crush" under special instructions. Nurse #7 placed the medication in the dispensing cup. An interview with Nurse #7 at this time revealed she had dispensed all the medications ordered for Resident #60 and was going to crush them to be administered to him. Nurse #7 stated this completed her medication preparation for Resident #60 and stated she was going to crush	F 759	Actions taken/systems put into place to reduce the risk of future occurrence include: From 12/11/2024 to 12/16/2024, the facility DON initiated in-services with all licensed nursing staff and medication aides related to medication administration. On 12/17/24, the facility's pharmacy nurse consultant in-serviced all licensed nurses and medication aides on Medication Administration (Rights of Medication Administration) and Medication Storage (Medication Cart Maintenance, Checking for expired medications, and Medication Disposal). Licensed nursing staff and medication aides who have not received the in-services will be educated upon their next scheduled shift. The licensed nursing home administrator (LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024. The DON and Chief Nursing Officer completed the North Carolina Board of Nursing (NCBON) Compliant Evaluation Tool (CET) for nurse #7 on 12/12/24. Following the completion of the NCBON CET, nurse #7 was suspended in a meeting with the facility DON, Administrator, Chief Nursing Officer, and Chief Operating Officer. How the corrective action(s) will be monitored to ensure the practice will not recur:	

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F 759	Continued From page 37 all the medications in the dispensing cup at this time and was prepared to administer them to Resident #60. Nurse #7 stated that after she crushed all the other medications, she would open the Flomax capsule and pour the contents into the medication dispensing cup. Nurse #7 stated Resident #60 liked his crushed medications mixed in with apple sauce. Nurse #7 proceeded to crush all the medications that were in the dispensing cup with the exception of the Flomax capsule. Nurse #7 placed all of the medications in the small bag provided bag provided to "crush" the medications and positioned the bag in the machine to be crushed. Nurse #7 was asked at this time if all the medications should be crushed and she replied "yes" except for the Flomax because she would open the capsule and pour it over the other crushed medications before administering. Nurse #7 was also asked if she followed the physician's order for the Ciprofloxacin medication. Nurse #7 counted the amount of medications that should have been in the dispensing cup and realized at this time she put 2 tablets of the Ciprofloxacin in the dispensing cup instead of 1. Nurse #7 removed one of the tablets of Ciprofloxacin. Nurse #7 reviewed the dispensing card for the Protonix medication and read out loud "do not crush" from the label. Nurse #7 stated she had never realized the instruction "do not crush" was on the dispensing card and she had always crushed the medication. Nurse #7 removed the "do not crush" protonix medication from the bag. A phone interview was conducted with the Consulting Pharmacist on 11/21/24 at 3:27 PM. The Pharmacist stated that administering more	F 759	The DON and/or Designee will randomly complete random medication pass audits on two licensed nurses and/or med aides for four weeks, then once monthly for two months. The facility Pharmacy Nurse consultant will continue monthly audits, including medication pass audits with one licensed nurse or medication aide. The results of these audits will be monitored, and immediate follow-up will be completed by the DON and/or facility administrative nurses. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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F 759	Continued From page 38 than the ordered dose of the Ciprofloxacin could have caused the Resident stomach discomfort such as nausea, vomiting, and diarrhea. The Pharmacist stated the "do not crush" instructions were important to follow for the Protonix medication because if the medication was crushed in causes the medication to be least effective in managing the resident's gastrointestinal symptoms. An interview with the Director of Nursing (DON) on 11/20/24 at 3:30 AM revealed Nurse #7 should have read the entire order on the dispensing card and in her electronic medical record before dispensing the Ciprofloxacin medication in the medication cup and she should be following any special instructions, such as "do not crush" prior to administration. The DON stated the special instructions of "do not crush" were there for a reason and the direction should be followed.	F 759		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Consulting Pharmacist and staff interviews, the facility failed to administer the physician ordered hypotensive medication (a medication to increase blood pressure) 6 times in one month when the blood pressure reading required the administration of the medication for 1 of 3 residents (Resident #18) sampled for medication review.	F 760	F760 Significant Medication Error Immediate action(s) taken for the resident(s) found to have been affected include: On 11/20/24, the Director of Nursing (DON) educated medication aide #1 one-on-one about facility medication administration protocol, including the need to notify the nurse when follow-up.	12/19/24

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F 760	Continued From page 39 Findings included: Resident #18 was admitted to the facility on 08/23/24. Diagnoses included high blood pressure and Vitamin D deficiency. The Minimum Data Set (MDS) admission assessment dated 08/30/24 revealed Resident #18 was moderately cognitively impaired. A physician's order written on 09/11/24 for Midodrine (medication used to treat orthostatic hypotension (sudden fall in blood pressure that can occur when a person assumes a standing position) 5 milligrams (mg) give one tablet by mouth as needed for blood pressure less than 110/60 millimeter of mercury (mm/Hg). A physician's order written on 11/15/24 for Metoprolol Tartrate (a medication to treat high blood pressure) 25 mg give one tablet by mouth twice daily; hold for systolic blood pressure (SBP) less than 110 mm/Hg or diastolic blood pressure (DBP) less than 60 mm/Hg. A review of the November Medication Administration Record (MAR) revealed the Metoprolol Tartrate 25 mg was held 6 days due to low blood pressure readings as evidenced by nursing initials and a checkmark. The MAR also revealed the Midodrine 5 mg was not administered as evidenced by no nursing initials or checkmark. The blood pressure recordings were as follows: 11/06/24 90/40 mm/Hg 11/06/24 106/53 mm/Hg 11/07/24 100/60 mm/Hg 11/11/24 106/64 mm/Hg	F 760	Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: From 12/11/2024 to 12/16/2024, the facility DON initiated in-services regarding medication administration with all licensed nursing staff, including nurse #6 and medication aides. On 12/17/24, the facility's pharmacy nurse consultant in-serviced all licensed nurses and medication aides on Medication Administration (Rights of Medication Administration) and Medication Storage (Medication Cart Maintenance, Checking for expired medications, and Medication Disposal). Licensed nursing staff and medication aides who have not received the in-services will be educated upon their next scheduled shift. The licensed nursing home administrator (LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON and/or Designee will randomly complete random medication pass audits on two licensed nurses and/or med aides	

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F 760	Continued From page 40 11/12/24 108/57 mm/Hg 11/14/24 100/56 mm/Hg An interview with Medication Aide (MA) #1 on 11/20/24 at 10:30 AM revealed on 11/06/24, 11/07/24 and 11/14/24, the MA #1 stated as a medication aide she was not allowed to administer as needed (PRN) medications and she would have had to notify the nurse to administer the Midodrine when the blood pressure was low. MA #1 stated she did not notify the charge nurse on duty that Resident #18's blood pressure was within the parameters to receive the ordered Midodrine 5 mg and she should have. An interview was conducted with Nurse #6 on 11/21/24 at 11:10 AM. Nurse #6 confirmed she did not administer the Midodrine to Resident #18 on 11/06/24 and 11/11/24. Nurse #6 stated she did not realize the order was in place to administer Midodrine if the blood pressure was less than 110/60 mm/Hg. An interview was conducted with MA #2 on 11/21/24 at 12:55 PM. MA #2 stated she did not notify the charge nurse on duty on 11/12/24 that Resident #18 needed the Midodrine due to his low blood pressure. MA #2 stated as a medication aide she was not allowed to administer as needed medications, and she would have had to notify the nurse to administer the Midodrine. MA #2 stated she did not realize the order to administer Midodrine was in place. An interview was conducted with the Consulting Pharmacist via phone on 11/21/24 at 3:27 PM. The Pharmacist stated if the blood pressure the nursing staff had taken and recorded was within	F 760	for four weeks, then once monthly for two months. The facility Pharmacy Nurse consultant will continue monthly audits, including medication pass audits with one licensed nurse or medication aide. The results of these audits will be monitored, and immediate follow-up will be completed by the DON and/or facility administrative nurses. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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F 760	Continued From page 41 the parameters to receive the Midodrine 5 mg, she would have expected the nursing staff to administer the medication to help elevate the resident's blood pressure and reduce the possibility of getting orthostatic hypotension. She stated not giving the Midodrine to raise the blood pressure may cause the resident's blood pressure to go even lower with the next dose of Metoprolol. The Pharmacist added that she had not done the monthly drug regimen review as yet for Resident #18, but if she had she would have put in her report a recommendation noting missed opportunities to administer the Midodrine based on the blood pressure parameters. An interview was conducted with the Director of Nursing (DON) on 11/21/24 at 3:30 PM. The DON stated if there were parameters in place to hold a medication or give a medication, he expected his nursing staff to follow the order as written. The DON stated the Medication Aides should have notified the nurse of the blood pressure so the Nurse could have administered the ordered medication. The DON added that parameters were in place for a reason and not following the order could result in a negative outcome for the resident.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/19/24

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F 761	Continued From page 42 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired opened multidose medications for 2 of 4 medication carts reviewed (300 and 400-hall medication carts). Findings included: a. An observation of the 300 Hall medication cart was conducted on 11/21/24 at 10:30 AM in the presence of Nurse #5. The medication cart contained an opened bottle of Geri-dryl (generic antihistamine brand of Benadryl) 25 milligrams (mg) with an expiration date of 10/24. An interview was conducted with Nurse #5 on 11/21/24 at 10:30 AM and she revealed the night shift nurses were supposed to check the medication carts during their shift for any expired medications. She stated she also checked her medication cart for expired medications but she	F 761	F761 Label/Store Drugs & Biologicals Immediate action(s) taken for the resident(s) found to have been affected include: The expired medications were removed immediately from the 300 and 400 hall medication carts on 11/21/2024 following surveyor notification. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: From 12/11/2024 to 12/16/2024, the facility DON initiated in-services with all	

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F 761	Continued From page 43 overlooked the Geri-dryl bottle. Nurse #5 stated she did not administer any of this medication today. b. An observation of the 400 Hall medication cart was conducted on 11/21/24 at 11:30 AM in the presence of Nurse #5. The medication cart contained an opened bottle of Liquid Tylenol (pain relieving medication) 16 ounces with an expiration date of 09/24/24 and an opened bottle of Simethicone (a medication to relieve intestinal gas) 80 mg with an expiration date of 08/24/24. An interview was conducted with Nurse #5 on 11/21/24 at 11:30 AM and she revealed the night shift nurses were supposed to check the medications carts during their shift for any expired medications. She stated she also checked her medication cart for expired medications but she overlooked the Liquid Tylenol and the Simethicone. She stated both medications were expired and should have been removed from the medication cart and that neither medication was administered today. An interview was conducted with the Director of Nursing (DON) on 11/21/24 at 3:30 PM. The DON stated it was the facilities responsibility to ensure that all medications on the medication carts should not be expired. He stated the night shift nurses were responsible for going through the medication carts and the medication rooms since they had more "down" time to ensure that there were no medications on the carts or in the storage room that had expired.	F 761	licensed nursing staff, including nurse #6 and medication aides, regarding medication administration. On 12/17/24, the facility's pharmacy nurse consultant in-serviced all licensed nurses and medication aides on Medication Administration (Rights of Medication Administration) and Medication Storage (Medication Cart Maintenance, Checking for expired medications, and Medication Disposal). Licensed nursing staff and medication aides who have not received the in-services will be educated upon their next scheduled shift. The licensed nursing home administrator (LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON and/or Designee will randomly audit five medication carts for expired medications weekly for four weeks and monthly for two months. The facility Pharmacy Nurse consultant will continue monthly audits, including medication storage audits (medication carts and medication rooms). The results of these audits will be monitored, and the DON and/or facility administrative nurses will complete immediate follow-up. Audit results will be reviewed by the QAPI	

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F 761	Continued From page 44	F 761	Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		12/19/24

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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 842	Continued From page 45 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility inaccurately documented the removal of a lidocaine patch (medicated topical pain patch) and the presence of a fall mat for 1 of 3 residents (Resident #67) observed	F 842	F842 Medical Records- Identifiable Information Immediate action(s) taken for the resident(s) found to have been affected include:	

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F 842	Continued From page 46 during a medication pass, and inaccurately documented the removal of a dressing to an arterial venous access (vascular access to arm used for dialysis treatments) for 1 of 2 residents (Resident #69) observed for dialysis. Findings included: Resident #67 was admitted to the facility on 02/20/24. Diagnoses included stroke with left side weakness, abnormalities of gait and mobility, lack of coordination, pain, and limitation of activities due to disability. 1a. A physician's order was written on 02/24/24 for Lidocaine external patch 4%, apply to back topically one time a day for pain. Remove after 12 hours. The Minimum Data Set (MDS) annual assessment dated 11/06/24 revealed Resident #18 was cognitively intact and was on a pain medication regimen for occasional moderate pain. During a medication pass with Medication Aide (MA) #1 on 11/20/24 at 8:30 AM, MA #1 revealed she was going to apply a Lidocaine Patch 4% to Resident #67's back. Prior to applying the patch, MA #1 noted the existing patch on Resident #67's back was dated 11/19/24. MA #1 stated, "the nurse left your patch on last night," and she then removed the existing patch. There was no redness or skin irritation noted. MA #1 applied the new patch to Resident #67's back. Review of the November 2024 Medication Administration Record (MAR) revealed the Lidocaine external patch 4% was signed off as	F 842	A licensed nurse immediately removed the lidocaine patch from Resident #67 on 11/20/2024 after the surveyor notified them of the issue. A licensed nurse placed The Fall mat in resident #67□s room immediately on 11/20/2024 after notification by the surveyor. A licensed nurse removed the dressing to arterial venous access from resident #69 on 11/21/2024 after notification by the surveyor. Identification of other residents having the potential to be affected was accomplished by: All residents in the facility have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: From 12/11/2024 to 12/16/2024, the facility DON initiated in-services with all licensed nursing staff and medication aides, including medication aide #1 and nurse #5, regarding documentation and the importance of maintaining a complete and accurate medical record. Licensed nursing staff and medication aides who have not received the in-services will be educated upon their next scheduled shift. The licensed nursing home administrator (LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024.	

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F 842	Continued From page 47 being removed by Nurse #5 on 11/19/24 at 9:00 PM. An interview with Nurse #5 on 11/20/24 at 4:14 PM revealed she should not have signed off on the MAR that she removed the Lidocaine patch when she did not. Nurse #5 stated she was quickly signing off her medications to be administered and had signed off the removal of the Lidocaine patch before she was supposed to remove the patch and then forgot to remove the patch because she got busy. An interview was conducted with the Director of Nursing (DON) on 11/21/24 at 3:30 PM. The DON stated he would have expected his nursing staff to remove the Lidocaine Patch as ordered and to then to sign it off on the Medication Administration Record after it was removed. The DON stated had Nurse #5 removed the Lidocaine Patch from Resident #67 and then signed it off as completed there would be no error or inaccurate documentation. 1b. A physician's order was written on 02/27/24 for nurse to check fall mat placement every shift. An observation of Resident #67's room on 11/20/24 at 10:10 AM revealed there was no fall mat at his bedside. Review of the November 2024 MAR revealed the order to check fall mat placement was signed off as being checked for placement by Medication Aide #1 on 11/20/24. An interview with MA #1 on 11/20/24 at 10:10 AM revealed she signed off on the MAR that the fall mat was in place and she should not have since it	F 842	How the corrective action(s) will be monitored to ensure the practice will not recur: The DON and/or Designee will randomly complete audits on five medication administration and/or treatment records to ensure that medications and treatments have been administered as ordered. The audit frequency will be weekly for four weeks, then once monthly for two months, and will include monitoring for removing lidocaine patches and the presence of fall mats. The facility Pharmacy Nurse consultant will continue monthly audits, including monitoring documentation during medication pass audits with one licensed nurse or medication aide. The results of these audits will be monitored, and immediate follow-up will be completed by the DON and/or facility administrative nurses. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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F 842	Continued From page 48	F 842		

was not there. She stated she was just clicking off all medications and must have clicked off the fall mat placement in error.

An interview was conducted with the Director of Nursing on 11/21/24 at 3:30 PM. The DON revealed the fall mat was needed to aide in keeping Resident #67 from serious injury if he should fall from bed. The DON reported he would have expected Medication Aide #1 to check for fall mat placement before signing off that it was in place.

2. Resident #69 was admitted to the facility on 10/10/24. Diagnoses included, in part, end stage renal disease (ESRD) and dependent on dialysis.

The MDS admission assessment dated 10/17/24 revealed Resident #69 was moderately cognitively impaired and was receiving dialysis services.

A physician's order written on 10/11/24 revealed Resident #69 was to receive dialysis on Monday, Wednesday, and Friday.

A dialysis communication sheet sent to the facility dated 10/20/24 written by the Dialysis Nurse revealed under other concerns a note indicating "please remove gauze dressing from dialysis site the night of dialysis. Leaving it on can damage the access."

A physician's order was written on 11/01/24 to remove dressing to left arm dialysis access site approximately one hour after return from dialysis each evening shift on Monday, Wednesday, and Friday.

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F 842	Continued From page 49	F 842		

Review of the November 2024 MAR revealed the order to remove the dressing to left arm dialysis access site was signed off as being removed by Nurse #5 on 11/20/24.

An observation of Resident #69 on Thursday, 11/21/24 at 9:30 AM, revealed Resident #69 was noted to have his dressing in place to his left arm access site.

An interview with Nurse Aide #4 on 11/21/24 at 9:30 AM revealed she was getting Resident #69 ready for his bed bath at this time and she was removing the dressing from Resident #69's left arm access site. She stated the dressing had been on since yesterday's dialysis treatment and she did not see any blood seeping through the dressing and felt it was safe to remove.

An interview was conducted with Nurse #5 on 11/21/24 at 10:45 AM. Nurse #5 revealed there was no order to remove the dressing so she did not remove the dressing. Nurse #5 reviewed the physician orders and confirmed there was an order in the MAR to remove the dressing. Nurse #5 stated she should not have signed off removing the dressing when she did not remove the dressing. Nurse #5 stated she did not realize she signed the order off in the MAR.

An interview was conducted with the Director of Nursing on 11/21/24 at 3:30 PM. The DON reported there had been a concern in the past that the dressing to Resident #69's access site was not being removed the night of the dialysis treatment and he had addressed the concern with his nursing staff to ensure the dressing was removed after each dialysis treatment on Monday, Wednesday and Friday. The DON

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F 842	Continued From page 50 stated he had an order put in place on 11/01/24 to remind nursing staff to remove the dressing from the access site. He stated Nurse #5 should not have documented that she removed the dressing, when in fact, she did not. He stated it was inaccurate documentation.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		12/19/24

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F 880	Continued From page 51 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, facility staff failed to implement their policy for Enhanced Barrier Precautions (EBP)	F 880	F880 Infection Control- EBP Immediate action(s) taken for the resident(s) found to have been affected	

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F 880	Continued From page 52 when Nurse #1 and Nurse #3 failed to apply a gown before entering residents' room to provide care for 2 of 2 residents (Resident #40 and Resident #12). The deficient practice occurred for 2 of 2 staff members observed for infection control practices. Findings included: Review of the facility's policy titled "Enhanced Barrier Precautions (EBP)" dated 04/01/24 read in part: EBPs require use of gown and gloves by staff during high-contact patient care activities. During an observation on 11/20/24 and 11/21/24 an EBP sign was posted by Resident #40 and Resident #12's room door that read in part: All Health Personnel must: wear gloves and gown for the following high-contact resident care activities: Device care or use for tracheostomy, or wound care, with any skin opening requiring a dressing. a. An observation was conducted on 11/20/24 at 2:05 PM of Nurse #3 providing tracheostomy care for Resident #40. Nurse #3 performed hand hygiene upon entering the room and applied a clean pair of gloves and mask, but did not apply a gown. Nurse #3 removed the old gauze around the tracheostomy and cleaned around the inner and outer cannula of the tracheostomy with a normal saline soaked gauze. He then removed his gloves and performed hand hygiene. He applied a clean pair of gloves, and gown after being asked prior to the inner cannula change if a gown was required for trach care. Nurse #3 was asked prior to the inner cannula change if a gown was needed during high contact resident care activities like tracheostomy care. Nurse #3 stated he did not think a gown was necessary. Nurse #3	F 880	include: On 11/22/24, the Director of Nursing (DON) educated Nurse #1 and Nurse #3 about the facility's Enhanced Barrier Precautions policy (EBP). Identification of other residents having the potential to be affected was accomplished by: All facility residents on Enhanced Barrier Precautions (EBP) have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: On 12/11/2024- 12/17/24, the DON initiated in-services with all licensed nursing staff, certified medication aides, Certified Nursing Assistants, and therapy staff related to Infection Control and following the facility policy on EBP. Licensed nursing staff, medication aides, certified nursing assistants, and therapy staff who have not received the in-services will be educated on their next scheduled shift. The licensed nursing home administrator (LNHA) completed an ad hoc Quality Assessment/Performance Improvement (QAPI) meeting with interdisciplinary (IDT) team members on 12/11/2024. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON and/or designee will randomly monitor five employees for utilization of EBP per facility policy weekly for four	

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F 880	Continued From page 53 then read the EBP sign on the resident's door during the interview and agreed that a gown was indeed necessary when doing high-contact care activities, which included tracheostomy care. An interview conducted with Nurse #3 on 11/20/24 at 2:30 PM revealed he received training on the facility's EBP policy and procedure. Nurse #3 stated he was aware Resident #40 was on EBP due to having a tracheostomy and Nurse #3 indicated he did not wear a gown when providing Resident #40's tracheostomy care prior to reading the sign on the door because he did not think it was a high-contact care. Nurse #3 indicated after he reviewed the EBP signage on Resident #40's door, he realized then that according to the signage he should have worn a gown when providing tracheostomy care. b. On 11/21/24 at 2:07 PM an observation was made of Wound Nurse #1 in Resident #12's room finishing up with wound dressing changes on two of the resident's wounds, one on the resident's right forearm and the other on her lower right leg. Wound Nurse #1 stated Resident #12 was under EBP for multiple wounds that needed daily dressings and treatment. The EBP signage located on Resident #12's door instructed staff to wear a gown and gloves during high contact resident care activities such as changing briefs or assisting with toileting and wound care for chronic wounds. Gowns were available in the personal protective equipment (PPE) cart located just outside the resident's door. Nurse #1 was observed in the resident's room, performing hand hygiene and applying gloves. Wound Nurse #1 completed Resident #12's wound care without applying a gown.	F 880	weeks and monthly for two months. The results will be taken to the monthly QAPI meeting to ensure compliance. The Corporate Infection Control Director will perform random infection control audits monthly for two (2) months to monitor hand hygiene and compliance with enhanced barrier precautions. Audit results will be reviewed by the QAPI Committee biweekly until consistent, substantial compliance has been achieved, as determined by the committee.	

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F 880	Continued From page 54 An interview was conducted on 11/21/24 at 2:15 PM with Wound Nurse #1. Wound Nurse #1 was asked if Resident #1 was under any kind of precautions and she replied "yes", Enhanced Barrier Precaution's which meant she needed to wear a gown and gloves before entering the resident's room. Wound Nurse #1 stated she would typically wear a gown while providing wound care however had just forgotten to put it on. She stated she would normally put on a gown while providing any wound care in the building. On 11/21/24 at 3:00 PM during an interview with the Assistant Director of Nursing (ADON), who was also the facility's Infection Control Preventionist (ICP), stated all the staff knew to abide by the different types of precautions posted on the residents' door and to follow the assigned PPE during high contact resident care activities. The interview revealed Wound Nurse #1 and Nurse #3 should have both worn a gown while providing either tracheotomy care or wound care for Resident #40 and Resident #12.	F 880		