STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint survey was conducted 12/16/2024 through 12/19/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # JAVU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/16/2024 to 12/19/2024. The survey team returned to the facility on 1/8/2025 to obtain additional information and exited on 1/8/2025. Therefore, the exit date was changed to 1/8/2025. Survey Event ID # JAVU11. The following intakes were investigated: NC00223225, NC00221516, NC00209452, NC00223972, NC00220217, NC00218446, NC00218713, NC00218727, NC00223532, NC00205752, NC00218527, NC00205872, NC00208422, NC00210474, NC00210615, NC00210697, NC00210782, NC00214643, and NC00217410. 12 of 65 complaint allegations resulted in a deficiency. Past Non-compliance was identified at: CFR 483.12 at F600 at a scope and severity G. Non-compliance for F 600 began on 10/17/24. The facility corrected the deficiency effective 11/02/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		2/10/25

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

Electronically Signed | 02/06/2025

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F 550	Continued From page 1	F 550		

access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, and staff and resident

Preparation and/or execution of this plan

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F 550	Continued From page 2 interviews and record review, the facility failed to provide a dignified dining experience when staff did not assist Resident #77 with his meal at eye level. This failure occurred for 1 of 4 sampled residents observed for dignity with dining. The findings included: Resident #77 was admitted to the facility on 6/15/22. Diagnoses included vascular dementia and Alzheimer's disease. A care plan revised 9/25/24 recorded Resident #77 had self-care performance deficits and required substantial, maximal staff assistance with eating. An 11/21/24 quarterly Minimum Data Set assessment indicated Resident #77 had moderate difficulty hearing, adequate vision, clear speech, understood by others, able to understand others, severely impaired cognition and required staff assistance with eating. A continuous observation occurred on 12/17/24 from 1:25 PM until 1:35 PM. Resident #77 was in bed, the head of bed was elevated, and his lunch meal tray was on an overbed table positioned across his lap area. There were two chairs in the room. Resident #77 fed himself pudding and then stopped eating. NA #1 entered the room and asked Resident #77 if he wanted to finish eating and he replied "Yeah, I'm hungry." NA #1 stood to the left side of the bed and fed Resident #77 his lunch meal while Resident #77 looked straight ahead. NA #1 and Resident #77 did not make eye contact during the observation. NA #1 was interviewed on 12/17/24 at 1:36 PM.	F 550	of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F550 Resident Rights 1. CNA# 1 provided 1:1 education regarding resident rights to be provided dignified dining experience when assisting a resident with a meal that includes ensuring that you are at eye level with the resident on 12/18/24 by the Director of Nursing. 2. On 12/18/24, the Director of Nursing /designee completed a facility audit to identify residents needing assistants with meal consumption. Those that were identified are at risk for the deficient pratice. 3. Staff Development Coordinator /designee provided education to Licensed Nurses and Certified Nursing Assistants on resident rights to be provided with dignified dining experience when assisting a resident with a meal that includes ensuring that you are at eye level with the resident. Education will be completed by 2/10/25.	

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F 550	Continued From page 3 During the interview, NA #1 described Resident #77 as an alert Resident with confusion. NA #1 stated that Resident #77 fed himself sometimes, usually his dessert, but also needed staff's assistance with his meal when he got tired. NA #1 stated he was trained to sit down when he assisted residents with their meals, but on 12/17/24 he did not see that there were two chairs in the room. NA #1 further stated, "I should sit down; I will correct that going forward." Resident #77 was interviewed on 12/17/24 at 1:37 PM. When he was asked if he would prefer staff sat down when staff assisted him with a meal, he replied "Yeah, that's what we should do, we should sit down, right?" An interview occurred on 12/19/24 at 1:35 PM with the Director of Nursing (DON), the Administrator and the Regional Clinical Director. During the interview, the DON stated staff were trained to assist residents with meals by reviewing the tray card, providing foods per the diet order, set up the tray in front of the resident and to assist residents with the level of assistance required by the resident according to the plan of care. The DON stated that if the resident ate meals in their room, staff should be seated so that the staff member fed the resident at eye level for the resident's dignity. The Administrator stated, residents should receive assistance with their meals at eye level and staff should also not stand over the resident, so the resident did not feel rushed. The Regional Clinical Director stated on 12/17/24 NA #1 should have been seated when he assisted Resident #77 with his meal because there were chairs available in the room.	F 550	Newly hired licensed Nurses, and certified nursing aides will receive the education during new hired orientation. Any licensed Nurse or Nursing Assistant including agency staff that cannot be reached within the initial education time frame will not take an assignment until they have received this education by the Director of Nursing/designee. 4. The Director of Nursing/ designee will complete audit of staff assisting residents with a meal to ensure that staff are providing dignified dining experience that includes ensuring the staff is at eye level. The observations will be completed three times a week for four weeks, then two times a week for four weeks, then one time a week for four weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QAA) Committee by the Directof of Nursing monthly times three months. The QAA committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Compliance Date: 2/10/2025	

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F 575	Continued From page 4	F 575		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, Complaint Intake, Adult Protective Services, the Office of the State Long-Term Care Ombudsman program, and the Protection and Advocacy network. This observation occurred for 3 of the 4 days during the onsite recertification survey.	F 575	F575 Required Postings 1. On 12/18/24 the Nursing Home Administrator updated the required posting to include: The list of names, addresses, (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, Compliant Intake,	2/10/25

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F 575	Continued From page 5 The findings included: An observation of the facility was completed on 12/16/24 at 11:50 AM. The observation revealed no signage or postings which included name and contact information for the State Survey Agency, Complaint Intake, Adult Protective Services, the Office of the State Long-Term Care Ombudsman program, and the Protection and Advocacy network. Follow up observations of the facility were completed 12/17/24 at 8:50 AM and 3:50 PM. The observation revealed no signage or posting which included name and contact information for the State Survey Agency, Complaint Intake, Adult Protective Services, the Office of the State Long-Term Care Ombudsman program, and the Protection and Advocacy network. On 12/18/24 at 11:56 AM, a tour of the facility was completed with the Administrator. The observation revealed no signage or posting which included name and contact information for the State Survey Agency, Complaint Intake, Adult Protective Services, the Office of the State Long-Term Care Ombudsman program, and the Protection and Advocacy network. An interview was completed with the Administrator on 12/18/24 at 12:03 PM. The Administrator stated signage or posting which included name and contact information for the State Survey Agency, Complaint Intake, Adult Protective Services, the Office of the State Long-Term Care Ombudsman program, and the Protection and Advocacy network should be posted so that residents, families or visitors have access to file concerns or complaints.	F 575	Adult Protective Services, the Office of the Long - Term Care Ombudsman program, and the Protection and Advocacy Network. 2. On 12/18/2024 the Nursing Home Administrator completed an audit of facility posting to ensure that all required posting were posted, in a form and manner accessible and understandable to residents, resident representatives. There were no additional concerns noted. 3. On 12/18/25 the Vice President of Operations provided education to Nursing Home Administrator regarding the required posting that included: The list of names, addresses, (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, Compliant Intake, Adult Protective Services, the Office of the State Long - Term Care Ombudsman program, and the Protection and Advocacy Network. 4. The Nursing Home Administrator will complete an audit of facility posting to ensure that all required posting is posted, in a form and manner accessible and understandable to residents, resident representatives. The observations will be completed three times a week for four weeks, then two times a week for four weeks, then one time a week for four weeks.	

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F 575	Continued From page 6	F 575	Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QAA) Committee by the Nursing Home Administrator monthly times three months. The QAA committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of compliance 2.10.2025	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		2/10/25

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F 584	Continued From page 7 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews the facility failed to provide a clean and sanitary environment for 16 of 16 resident rooms on the 200 hall (Rooms 208, 209, 211, 213, 215, 217, 218, 219, 220, 221, 222, 223, 224, 226, 228, and 233), 4 of 4 resident rooms on the 300 hall (Rooms 341, 355, 357, and 365), 8 of 8 resident rooms on the 100 hall (Rooms 103, 107, 113, 115, 120, 121, 130, and 134), 3 of 3 community restrooms on the 100 hall (Rooms 109, 125, and 126), and 1 of 2 shower rooms on the 100 hall (Room 127). Findings included: 1. On 12/18/2024 at 8:30 am an observation was made of the 200-hall rooms and bathrooms for approximately 25 minutes: a. Room 209 had dark brown and black stains on	F 584	F584 Safe/Clean /Environment 1. Resident rooms that included 208, 209, 211, 213, 215, 217, 218, 219, 220,221, 222, 223, 224, 226, 228, 233; 341,355, 357, 365, and 103, 107, 113, 115, 120, 121,130, 134 and 3 restrooms and resident rooms 109, 125, 126 and shower rooms on the 100 hall and resident room 127 walls, window seals, floors, basebroads and toilets were cleaned to remove grime build up and stains on or before 2/10/25 by the housekeeping staff. 2. Facility audit of resident rooms, shower rooms and bathrooms was completed by the Vice President of Operations and the Administrator on 12/23/2024 to ensure	

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F 584	Continued From page 8 the walls to the door side of the room and the window side of the room. Grime buildup was observed around the edges of the floors in the room at the baseboards. b. Room 211 had dark brown stains on the walls at the door and the window side of the room. There was built up black grime around the baseboards in the room. c. In the shared bathroom for Room 209 and Room 211 there were dark brown stains on the walls behind the commode, on the bathroom door, and on the wall across from the commode. d. Room 213 had dark brown stains on the wall at the door and grime build up around the edges of the floor. e. Room 215 had food on the floor, dark brown stains to the walls, and black grime build up around the edges of the floor at the baseboards. f. The shared bathroom for Room 213 and Room 215 had a commode with a thick, dark brown substance on the seat and front of the commode and black grime buildup around the commode base. g. Room 217 had several dark brown stains on the walls of the room that appeared to be a liquid that ran down the walls and dried. h. Room 219 had several dark brown stains on the lower walls at the bed. i. The shared bathroom for Room 217 and Room 219 had a thick, dark brown substance on the commode lid and dark brown stains on the wall	F 584	that walls, window seals, floors, baseboards and toilets were free of grime build up and stains. Facility resident rooms, shower rooms and bathrooms will be cleaned by housekeeping staff using the 5-step cleaning and Deep cleaning Process on or by 2/10/25. 3. Housekeeping Director/designee provided education to Healthcare Services Group on 5 step cleaning method and deep cleaning of rooms. The education will be completed by 2/10/25. Newly hired housekeeper staff will receive the education during new hire orientation. Housekeeping staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this education by the Director of Nursing/designee. 4. Nursing Home Administrator /designee will complete audit of 10 sampled areas including resident rooms, community restrooms and shower rooms to ensure that walls, window seals, floors, baseboards and toilets are free of grime build up and stains. The audits will be completed three times a week for four weeks, then two times a week for four weeks, then one time a week for four weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QAA) Committee by the	

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F 584	Continued From page 9 around the commode. j. Room 218 had a large dark brown stain under the window and stains to the wall at the door. k. Room 220 had dark brown splattered stains at the window side of the room and dark brown drip stains on the wall at the door. l. The shared bathroom for Room 218 and Room 220 had multiple brown stains on the walls of the bathroom and a thick, dark brown substance on the commode seat. m. Room 221 had dark brown stains to splatter on the wall at the door and the wall at the window. n. Room 223 had dark brown stains on the walls at the door and the window and the over the bed table had a large (approximately 15 cm) area of thick, sticky residue on the surface. o. The shared bathroom for Room 221 and 223 had brown stains on the walls and a thick, brown substance on the commode seat, and grime buildup around the bottom of the commode and around the baseboards. 2. On 12/18/2024 at 3:36 pm an observation was made of room 208 and dark brown stains were on the walls on the window and door side of the room and black grime build up was observed to the edges of the base of the commode. a. The resident who resided in Room 208 bed-A (assessed as cognitively intact on the 11/1/24 annual Minimum Data Set (MDS) assessment), was interviewed on 12/19/2024 at 1:15 pm. The resident stated the Maintenance Director came in	F 584	Nursing Home Administrator monthly times three months. The QAA committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 2.10.2025	

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F 584	Continued From page 10	F 584		

early and grouted around the base of the commode in her bathroom to cover the black grime build up around the base of the commode, but no one cleaned around the base of the commode or tried to clean her walls. The resident stated it bothered her that her room and bathroom were dirty.

b. The resident who resided in Room 208 bed-B (assessed as cognitively intact on the 11/3/24 significant change MDS assessment), was interviewed on 12/19/2024 at 1:23 pm and she stated it really bothered her that her room is not cleaned like it should be. She stated she would clean the room herself if she was able.

3. On 12/18/2024 at 8:55 am an observation was made of the 300-hall rooms and bathrooms for approximately 15 minutes:

a. Room 341 had dark brown stains on the door and window side of the room. The bathroom door had multiple dark brown stains on the outside and inside of the door, there was grime buildup around the edges of the commode and the baseboards. There was a thick, dark brown substance on the front of the commode.

During the observation of Room 341, the resident who resided in the room (assessed as cognitively intact on the 11/13/2024 quarterly Minimum Data Set (MDS) assessment) was interviewed and stated the housekeeping staff came in to clean the rooms but they did not wash the walls, and she did not know when her floor was last stripped of wax and rewaxed, and deep cleaned. The resident stated it bothered her that her room and bathroom were not clean.

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F 584	Continued From page 11	F 584		

b. Room 355 had dark brown and black stains on the walls at the door and grime buildup around the edges of the baseboards. The bathroom had grime buildup around the edges of the baseboard and around the toilet.

c. Room 357 had dark brown stains on the walls at the door and window side of the room and grime build up around the commode and baseboards of the room and bathroom.

d. Room 365 had dark brown stains on the walls of the room and the bathroom had dark brown build up of grime at the edges of the commode and yellow liquid on the commode seat and the floor in front of the commode. The bathroom floor had reddish, brown stains.

4. An observation of the 200-hall Memory Care Unit was completed 12/18/2024 at 9:10 am for approximately 15 minutes:

a. Room 233 had multiple brown stains on the wall on the door and window side of the room and there was buildup of grime around the baseboards.

b. Room 226 was observed and had brown stains on the walls on the door and window side of the room.
c. Room 228 had brown stains on the walls on the door and window side of the room.

d. The shared bathroom for Room 226 and Room 228 had a thick, brown substance on the front of the commode and the wall beside the commode.

e. Room 224 had dark brown and black stains on the walls at the door and window side of the room

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and black grime build-up around the baseboards, and a dark brown stain that was approximately 4 centimeters by 1 centimeter beside the bathroom door.

f. Room 222 had dark brown and black stains to the walls at the window and the door side of the room.

g. The floors and walls of the shared bathroom for Room 222 and Room 224 had multiple dark brown stains and there was black grime buildup around the baseboards and base of the toilet.

5. An observation of the 100-hall was conducted on 12/18/2024 at 10:00 am for approximately 25 minutes:

a. Room 115 was observed and had dark brown stains under the sink in the room, under the window and on the wall behind the bed.

b. Room 113 had brown splatters were observed running down the inside of the door and black grime build up was noted to the edges of the baseboards.

c. Room 107 had multiple brown and red stains on the floor and black grime build up around the baseboards.

d. Room 103 had grey stains on the inside of the sink, multiple dark brown stains on the floor, and dark brown stains under the sink.

e. Room 120 had multiple brown stains around the sink.

f. Room 121 had multiple brown stains on the

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walls at the door and window side of the room.

g. Room 130 had dark rust stains running down the wall under the sink to the floor in the room.

h. Room 134 had dark brown and black stains on the walls around the back of the bed and under the sink.
During the observation of Room 134, the resident who resided in the room (assessed as cognitively intact on the 10/11/24 Minimum Data Set assessment), was interviewed and stated she had not seen housekeeping clean her walls and it bothered her that they had dark brown and black stains.

i. Room 127, a shower room on the 100- hall, had black grime buildup around the edges of the baseboards and the toilet and dark brown stains on the front of the commode.

j. Room 109, a community restroom for residents, had black buildup of grime at the edges of the baseboards, black buildup of grime around the base of the commode and dark brown stains behind the sink.

k. Room 125, a community restroom for residents, had black grime build up around the baseboards of the room and the walls and the commode had a thick, dark brown substance on the seat of the commode.

l. Room 126, a community restroom for residents, had black grime build up around the edges of the bathtub and the baseboards.

During an interview with Housekeeper #1 on 12/18/2024 at 3:46 pm she stated she cleaned

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the tables, windowsills and swept and mopped the rooms when she did daily cleaning. She stated during a deep clean each month they cleaned under the furniture and washed the walls. The housekeeper stated she did not know why the rooms had so many stains on the walls and grime build up around the baseboards since the rooms should be deep cleaned once a month.

On 12/19/2024 at 1:48 pm the Floor Technician, who was responsible for stripping wax from the floor and reapplying wax when the rooms were deep cleaned monthly, was interviewed. He stated he did regular housekeeping duties when the facility did not have enough housekeepers, and he did not get to strip and wax the floors when he was assigned to work as a housekeeper.

An interview was conducted with the Housekeeping Manager on 12/18/2024 at 2:04 pm while touring the facility to discuss the stains on the walls of the rooms and bathrooms, and grime build up around the baseboards in the rooms and bathrooms of resident's rooms. The Housekeeping Manager stated the rooms did not look clean and there should not be grime on the floors and stains and splatters on the walls. The Housekeeping Manager stated the rooms should be cleaned daily by wiping down surfaces in the room, sweeping, mopping, and cleaning the bathrooms. He stated the rooms should be deep cleaned monthly which included the regular daily cleaning and changing the privacy curtain and cleaning under the beds. The Housekeeping Manager stated he did not know why there were so many stains on the walls or why there was grime buildup on the edges of the floors in the resident rooms and bathrooms.

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F 584	Continued From page 15 During an interview with the Administrator on 12/18/2024 at 2:38 pm he stated the housekeeping staff should clean the walls in the rooms and bathrooms daily and the rooms should be deep cleaned once a month. The Administrator stated the community bathrooms and shower rooms should be cleaned daily also.	F 584		
F 600 SS=G	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: Based on record review, and staff, family member, and physician interviews, the facility failed to protect Resident #87's right to be free from staff to resident abuse perpetrated by Nurse Aide (NA) # 1. During care, Resident #87 sustained a bruise to the left eye with pain when touched, a bloody nose, a 3-millimeter (mm) skin tear to the left elbow, and a scratch and discoloration to the left cheek. NA #1 stated Resident #1 was "fighting me like crazy" when he	F 600	Past noncompliance: no plan of correction required.	

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transferred the resident to bed from his wheelchair to provide incontinence care. The NA proceeded to force care upon Resident #87 as the resident remained combative and resistive to care, swinging his arms at the NA's face. The NA indicated following incontinence care, he dressed the resident and transferred the resident back to his wheelchair as the resident continued to swing his arms and resist. NA #1 stated the injuries to Resident #87 were caused from a "hard transfer". A reasonable person expects to be free from abuse in their home environment and suffering abuse at the hands of their caregiver would cause feelings such as fear, intimidation, anger, depression, and anxiety.

The findings included:

Resident #87 was admitted to the facility on 2/16/23 with a diagnosis that included dementia without behavioral disturbance, hallucinations and Parkinson's disease.

Significant Minimum Data Set (MDS) assessment dated 9/4/24 indicated Resident #87 was severely cognitively impaired and required substantial to maximum assistant for toileting and hygiene. Resident #87 had no rejection of care during the look back period and no behaviors directed towards others verbal/physical. Resident #87 further required partial to moderate assistance with bed to chair transfers and was incontinent of bowel and bladder.

Review of Resident #87's care plan dated 3/14/24 revealed he was resistive to care related to Dementia as he refuses to allow staff to help assist with activities of daily living (ADL). Resident #87 resided on the memory support

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unit. The goal stated attempts for resident to cooperate with care will be provided. The interventions included allow resident to make decisions about treatment regime, to provide sense of control; discuss with resident his objections or reasons, fears; offer as many alternatives as possible for resident to choose from and provide resident with opportunities for choice during care provisions.

Review of the initial allegation report (24-hour report) dated 10/27/24 revealed an allegation of abuse. The incident date was documented as 10/17/24 at 3:45 PM. The details of the report stated Resident #87 sustained a fall during patient care onto the bed. Resident #87 alleged he was hit. NA #1 was interviewed and suspended upon further investigation. The report continued that all staff involved were interviewed and skin assessments were initiated for all residents on the unit (secured memory care). It further indicated abuse and neglect education was initiated. Resident #87 had a small abrasion to his left elbow and bloody nose The police department, Adult Protective Services (APS) and Resident #87's responsible party was notified (family member).

An attempt to obtain a police officer report it was revealed the report was not assigned and was inactive.

The investigation (5 day working) report dated 10/23/24 revealed the witness of the incident was NA #1. The allegation was documented as not substantiated. The attached updated information related to the investigation report stated on 10/17/24 at 3:45 PM, Resident #87 stated he had been hit. Resident #87 had just completed

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incontinent care with NA #1. Resident was combative during care and had an unsuccessful transfer from his specialized reclining wheelchair to his bed. The investigation report revealed NA #1 stated Resident #87 was fighting during the transfer and fell onto the bed. Resident #87 hit the side of his head as well as his left arm on the headboard located at the top of the bed. Resident #87 could not name any alleged perpetrator. NA #1 continued to care for the resident. Once the care was complete, NA #1 transferred Resident #87 back to his specialized reclining wheelchair when NA #2 entered the room. NA #2 stated Resident #87 was still being combative throughout the transfer back into the specialized reclining wheelchair. NA #1 then brought Resident #87 to the floor nurse (Nurse #1). The Unit Manager (UM) then reported the incident to the Administrator who interviewed Resident #87. Resident #87 stated he was hit, and an investigation began immediately. The "outcomes to the resident" section of the report stated Resident #87 received a small skin laceration to his left elbow. He also sustained a small scratch on his left check as well as discoloration to his left cheek. Resident #87 also had a light nosebleed from his left nostril for approximately 45 minutes post incident. Resident #87 was stable and no new inquires had been identified. A brief but detailed description of all the steps taken into investigation of the allegation stated, "once the allegation was made, the Administrator interviewed the floor nurse (Nurse #1) and NA (NA #1). The Administrator, Regional Clinician, DON and UM watched the NA (NA #1) reenact the fall on the bed. NA #1 was immediately suspended. The Regional Clinician and Director of Nursing (DON) immediately assessed the resident, and x-rays were ordered

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to confirm no internal injuries". The note continued that Resident #87 was unable to be interviewed due to cognitive impairment. There were no witnesses to NA #1's incontinence care with Resident #87. NA #2 stated she returned to unit after taking dirty laundry. She witnessed Resident #87 being combative to NA #1 during care. A new skin issue was identified to include new skin issue under Resident #87's left eye, 3 mm skin tear to left elbow and slight blood coming from nostril. Skull x-ray completed with no injuries. In conclusion the report stated after all information was gathered, it was determined that Resident 87 hit his head on the headboard during incontinent care. It was believed that since the resident was combative during care, he assumed he was in a physical altercation due to his cognitive abilities. "The resident was transferred to bed was unsuccessful leading him to obtain a laceration and nosebleed".

An interview was conducted via telephone with NA#1 on 12/19/24 at 7:45 AM. He revealed he was assigned to the memory care/locked unit on 10/17/24. NA #1 described Resident #87 as a resident that would become aggressive during care to include transfers or incontinence care. Residents# 87's aggressive behaviors included swinging his hands at staff and pushing staff. He stated on the date of the incident he recalled being the only NA on the unit due to NA #2 taking out laundry bins off the unit. He indicated Resident #87 had an incontinent episode prior to meal delivery and he wanted to change the resident before meals arrived. NA #1 took Resident #87 to his room so he could provide incontinence care. When NA #1 picked Resident #87 up from his specialized reclining wheelchair to transfer Resident #87 to his bed, Resident #87

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became aggressive. Resident #87's aggression was described as swinging arms and hands and throwing punches at NA #1's face and body. NA#1 stated, "he was fighting me like crazy". "I couldn't get him to the bed as safe as I wanted to". Resident #87 fell to the bed during the transfer. He further revealed Resident #87 fell from a standing position. NA #1 indicated he did not know if Resident #87's body struck any object when he fell to the bed because NA #1 was protecting his face from Resident #87's swinging at NA #1's face. NA#1 further indicated he continued to do incontinence care and at that time did not notice any injuries to Resident #87. He indicated during incontinence care Resident #87 was trying to sit up while NA #1 was trying to get Resident #87 feet into the bed. Resident #87 continued to swing at NA #1's face during the reminder of incontinence care. Due to Resident #87 swinging at NA #1's face, NA #1 indicated he provided care with one hand blocking his face and with his other hand he changed Resident #87. After NA #1 got Resident #87 dressed he pulled the specialized reclining wheelchair close to the bed, picked up Resident #87 and put him back into his specialized reclining wheelchair. He indicated Resident #87 was still swinging his arms at him during the transfer from bed to chair. NA #1 stated he couldn't get Resident #87 in the chair as careful because he was swinging his arms during the transfer. NA#1 stated, "Resident #87 landing wasn't smooth". Once Resident #87 was in his specialized reclining wheelchair, NA#2 came into Resident #87's room. NA #1 stated he told NA #2 Resident #87 was "fighting him like crazy". He stated he did not see any injures to Resident #87 face but did notice a scratch to his elbow. He indicated he took Resident #87 to the medication cart at the end of the hall that was

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located near the dining room/activity room to show the hall nurse (Nurse #1) Resident #87's nose and scratch to his elbow. NA #1 indicated he noticed the blood coming from Resident #87 nose when he arrived at the medication cart. Nurse #1 asked NA #1 what happened, and he indicated he told Nurse #1 that Resident #87 was swinging at him during incontinence care. Nurse #1 asked NA #1 why NA #1 did not get another nurse for assistance and shot down the unit hallway to get management. He stated he was questioned about Resident #87 injuries and told the Administrator Resident #87 had a "hard transfer" to the bed and his chair. NA #1 provided the Administrator and a Corporate Nurse Consultant with a reenactment of the events. The specialized reclining wheelchair had the ability to be reclined, and the chair was not in the upright position during the transfer back into the specialized reclining wheelchair following incontinence care. He indicated the transfer might have gone better if the chair was in its upright position. He did not call out for help because NA #2 had left the unit and Nurse #1 was too far away. He did not stop care because while Resident #87 was resistive was because his incontinence care needed to be done, and the care had to be provided.

Telephone interview with NA #2 on 12/18/24 at 3:35 PM revealed Resident #87 could sometimes be aggressive with staff during care. Resident #87's aggression and combativeness was described as kicking and swinging his arms. She stated she did not witness what occurred on 10/17/24 with Resident #87 because she had taken dirty laundry off of the unit. She stated she when she arrived at Resident #87's bedroom, he was being combative with NA #1. She stated at

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the time she was assisting NA #1 with getting Resident #87 situated in his specialized reclining wheelchair she had not observed Resident #87 to have a bloody nose or any other injury. Following the incident he was interviewed by the Administrator.

Interview with Nurse #1 on 12/18/24 at 4:00 PM revealed Resident #87 had a diagnosis of Parkinson's disease as he would often shake. She stated Resident #87 would hold on to clothes and push at staff when doing care. She recalled being at the medication cart on 10/17/24 when NA #1 wheeled Resident #87 to the medication cart where she was working. She stated she looked at Resident #87 as he arrived at medication cart and observed him to have a little nosebleed, an abrasion under his left eye and a skin tear to his elbow. Nurse #1 asked NA #1 what happened and NA #1 told Nurse #1 that Resident #87 became combative and fell back onto the bed during a transfer. NA #1 might have also stated Resident #87 was swinging at him. She stated NA #1 initially stated Resident #87 had a fall then he changed his statement and indicated the resident fell to the bed. After speaking with NA #1 and observing Resident #87's injuries, she immediately separated the staff and resident and got Nurse #2/Unit Manager. The Administrator and the DON arrived shortly afterwards to assess the resident and begin an investigation.

In a continued interview with Nurse #1 on 12/18/24 at 4:55 PM revealed all NA#1 had to do was stick his head out of the door and request assistance and not continue to provide incontinent care.

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Interview with the Nurse #2/Unit Manager on 12/18/24 at 3:18 PM revealed at the time of the incident she was the unit manager for the locked unit. She indicated she was approached by Nurse # 1 while Nurse #2 was in a management meeting. Nurse #1 wanted Nurse #2 to come to the locked unit to look at Resident #87's face. She stated she recalled Resident #87 was seated in a wheelchair and his nose was bleeding and red. She indicated she did not recall the resident having an area of injury to his elbow or to his eye upon her observation. She stated after she saw Resident #87's injuries, she got the Administrator and the DON who also went to observe Resident #87 and conduct interviews.

Late entry Nursing progress note dated 10/18/24 stated the Director of nursing (DON), Unit manager (UM), Administrator and Regional (RDS) were notified and investigated new skin issues under Resident #87's left eye, 3-millimeter (mm) skin tear to the left elbow and slight blood was coming from Resident #87's nostril that occurred during resident care/brief change. The note continued that nursing assistant (NA#1) performed a re-enactment (to the Administrator, Regional Nurse, DON and UM) from transfer from specialized reclining wheelchair to bed, including care provided, and the transfers back to the specialized reclining wheelchair. Per interview, during transfer, resident became combative and resistive to care. Due to Resident #87's rigidity noted during re-enactment, the left side of his face and arm could have grazed the headboard. The mattress and headboard were inspected and assessed for rough areas, and none were found. Resident #87 had a bed without bed rails nor enablers nor anything that could have caused injury. Neurological checks

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were initiated, and no abnormalities were noted at that time. The Nurse Practitioner was notified, and no new orders were obtained. Resident #87's family member was notified and was present at Resident #87's bedside within 15 minutes of notification as she was in route to the facility upon being notified. The note continued that Resident #87 was up in is chair eating and interactive with his family member. Resident #87 showed no changes of behaviors.

Physician progress note dated 10/18/24 stated Resident #87 was seen for an acute visit. The note stated Resident #87 was asked to be seen by staff for a reported fall from standing position. Resident #87 was seen out of bed sitting in chair. The note further stated, "has swelling to left peri-orbital area (the region around the eyes) with erythema (skin redness). Reported that patient was being assisted by staff to standing position and was restless and fell forward on the bed possibly hitting headboard of bed. Pain with palpation of inner aspect of left peri-orbital area. Reported to have had epistaxis (nosebleed) not on blood thinners". Awaiting x-ray of left ocular (of the eye) area and Resident #87 was alert to self only and minimally able to follow commands.

Interview with the Administrator on 12/18/24 at 5:17 PM indicated Resident #87 was soiled and NA #1 wanted to change him before dinner. The Administrator stated he and the Nurse Consultant were summoned to the locked unit by the Nurse #2/Unit Manager. Upon observing Resident #87, Resident #87 had a cut on his arm and some redness round his eye and his nose was bleeding. He stated he did not recall any swelling. When he asked Resident #87 what happened, Resident #87 stated he was hit.

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When NA #1 was questioned about the incident he stated Resident #87 had soiled himself so took the resident to his room to provide incontinence care. NA #1 performed a re-enactment of the event. He stated initially Resident #87 was calm, prior to attempting to transfer the resident into the bed. As soon as NA #1 assisted Resident #87 to a standing position to pivot the resident, Resident #87 began swinging his arms at NA #1. NA #1 stated it was an "unsuccessful transfer" when he was taking Resident #87 from chair to bed. NA #1 told the Administrator that he did not see if Resident #87 struck any objects when he fell to the bed because NA #1 was covering his face to defend himself from Resident #87 swinging towards NA #1's face. Resident #87 fell to the bed diagonally which could have cause the injuries by the resident hitting the headboard. NA #1 indicated he had sat Resident #87 up on his bed and continued to provide incontinence care while Resident #87 continued to be aggressive towards NA #1. After NA #1 provided Resident #87 with incontinence care, NA#1 transferred Resident #87 back into his specialized reclining wheelchair. NA #1 indicated he noticed the injuries to Resident #87 once he had gotten him back into the wheelchair following the completion of his incontinence care. NA #1 indicated he assisted Resident #87 to the nursing cart.

Interview with Resident #87's family member on 12/28/24 at 6:59 PM revealed she was called by the facility and notified Resident #87 had a little cut under his eye and stated they wanted to get an x-ray. She stated when she arrived to the facility, she observed Resident #87 to have a slightly swollen eye and a bloody nose. His nose was not actively bleeding but there was dried

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blood. The family member was told by the facility NA #1 was trying to get Resident #87 in bed to change him and he hit his head on the headboard. Resident #87 was moving around while care was being provided making it difficult to pick him up. She stated the following day Resident #87's eye was swollen black and blue. The following day (10/18/24) the facility took x-rays of Resident #87 to ensure nothing was broken.

Interview with the facility Phy Physician on 12/19/24 at 3:24 PM indicated he recalled being notified about Resident #87 sustaining an injury due to a fall. He observed Resident #87 on 10/18/24 and he had a swollen eye. Resident #87 did not say he was in pain but showed signs of pain when the area was touched. Due to the resident showing signs of pain the physician ordered an x-ray. He described Resident #87 having Parkinson and having intermittent movements that he would not be in control of. He couldn't identify if the injury was due to a fall or due to the resident becoming combative during care.

Interview was conducted with the DON, Administrator and Nurse Consultant on 12/19/24 at 4:15 PM. They revealed they were notified of an incident involving Resident #87 while they were in a management on 10/17/24. The Nurse Consultant and the Administrator went to the locked unit and were told by Nurse #1 that Resident #87 had a little trickle of blood coming from his nose. Nurse #1 further indicated NA #1 had noticed the bloody nose when he got him back into the wheelchair following care. Resident #87 was seated in his wheelchair upon observation. A little bit of blood was noticed

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coming from Resident #87's nose, a small skin tear to his left elbow and redness to his eye. They stated the swelling to Resident #87's eye did not occur until later. NA #1 reenacted the event with the Nurse Consultant and the Administrator. NA #1 indicated that Resident #87 was being combative when he stood Resident #87 up to transfer him to the bed for incontinence care. The Administrator stated NA #1 kept using the words "unsuccessful transfer" meaning it wasn't a smooth transfer. NA #1 was asked if Resident #87 hit his head during the transfer and NA #1 was unsure. NA#1 indicated he did not know Resident #87 sustained any injury until he got Resident #87 back into his wheelchair. NA #1 should have stopped care when Resident #87 became combative and reapproached Resident #87. Resident #87 fell to the bed not the floor and the Administrator did not think it was considered a true fall. He stated although the reports used the words fall, he felt as though it was just how the words were being used.

The facility implemented the following Corrective Action Plan with a completion date of 11/2/24.

1. On 10/17/24 Resident #1 was transferred by Certified Nursing Assistant #1 while being combative and resistive to care. During transfer Resident #1 became combative resulting in Resident #1 sustaining a skin tear to left elbow and discoloration to the left peri-orbital area. Resident was assessed by Licensed Practical Nurse (LPN) #1 with noted dime size skin tear to left elbow and thin linear scratch under left eye with redness. LPN #1 notified the Provider and Resident Representative. LPN #1 received and processed order for x-ray to skull. LPN #1 notified Administrator who initiated investigation. The

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administrator submitted initial report on 10/17/24 at approximately 5pm. The administrator notified Monroe Police Department on 10/17/24 at 4:45pm and initial call to Adult Protective Services made at 6:08pm, they were closed at that time and a follow up call was completed on 10/18/24 at approximately 12:04 pm. CNA #1 was immediately removed from the assignment and interviewed with re- enactment of event with Administrator, Director of Nursing and Regional Nurse on 10/17/24. CNA #1 was suspended pending investigation 10/17/24. Administrator along with the Interdisciplinary Team member held an Adhoc Meeting on 10/17/24 to initiate Performance Improvement Plan. The Director of Nursing /designee completed staff interviews on memory care unit to include staff working with employee on 10/17/24 and 10/21/24. On 10/18/24 resident was assessed by in-house Provider with no new orders awaiting results of skull x-ray. On 10/18/24 Mobile X-ray completed skull x-ray at 11:39 and resulted 10/18/24 at 14:27 with no fractures, normal skull series. Director of Nursing and Administrator inspected the headboard with no negative findings on 10/18/24. After reviewing all investigative material to include re-enactment the most likely cause of injuries was resident bumping headboard. The administrator submitted the Initial Report to DHHS on 10/17/2024 and 5-day investigation to DHHS on 10/23/24. Resident #1's care plan was updated by Resident Care Specialist #1 on 10/21/24 to reflect the potential for combative and resistive behaviors during care and to identify triggers and how to de-escalate behaviors. Director of Nursing and Administrator spoke with Resident Representative to notify of updates to care plan on 10/21/24. Director of Nursing/designee updated the direct care staff on the care plan updates for Resident #1.

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2. Skin checks were completed on CNA#1 assigned area,100% of residents on the memory care unit. Skin checks completed by LPN #1, LPN #2, and Wound Care LPN #1 on 10/18/24.

3. The Director of Nursing / designee educated all Center staff on abuse, neglect and exploitation. Education completed 11/1/24.
The Director of Nursing/designee educated all Center staff on dementia training to include care of residents with combative behavior and resistance to care. Education completed 11/1/24.

4. Beginning on 10/18/24, the Director of Nursing /designee will observe 5 resident transfers to ensure residents transferred accurately according to the plan of care to include combative and or resistance to care 2 times a week for 12 weeks then monthly for 3 months. The decision was made to begin monitoring on 10/17/24 when the Performance Improvement Plan was reviewed by the Interdisciplinary Team.

Beginning on 10/19/24, data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 6 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

Date of Compliance: 11/2/2024

The Corrective Action Plan was validated on 01/08/25 and concluded the facility had

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F 600	Continued From page 30 implemented an acceptable Corrective Action Plan on 10/17/24. Interviews with nursing staff revealed the facility had provided education and training on abuse, neglect and exploitation, handling combative residents/ resistant to care and how to deescalate and provide care to aggressive residents. Nursing staff were observed transferring a resident with behavioral symptoms on the memory care unit. The audits conducted starting on 10/18/24 revealed nursing administration observed transfers to ensure the residents plan of care was followed and the transfer was completed in a safe and dignified manner. The audits continued weekly through the validation date. The corrective action plan was reviewed with the Quality Assurance committee on 10/17/24. The compliance date of 11/02/24 for the corrective action plan was validated.	F 600		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		2/10/25

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§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and

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F 623	Continued From page 32 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and resident, resident	F 623	F623 Notice of Transfer	

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F 623	Continued From page 33 representative, and staff interviews, the facility failed to notify the Resident and the Representative in writing of the transfer to the hospital for 2 of 4 residents reviewed for hospitalization (Resident #29 and Resident #19). The findings included: 1. Resident #29 was admitted to the facility 6/19/23. The significant change Minimum Data Set assessment dated 11/19/24 assessed Resident #29 to be cognitively intact. a. A nursing note dated 11/4/24 documented the Nurse Practitioner ordered Resident #29 to be sent to the hospital for evaluation for a change in condition. Review of the medical record revealed no written notice of transfer had been provided to Resident #29 or her representative. A nursing note dated 11/12/24 documented Resident #29 was readmitted to the facility. b. A nursing note dated 12/10/24 documented Resident #29 had a change in condition and the Nurse Practitioner ordered Resident #29 to be transferred to the hospital for evaluation. Review of the medical record revealed no written notice of transfer had been provided to Resident #29 or her representative. A nursing note dated 12/13/24 documented Resident #29 was readmitted to the facility.	F 623	1. Resident #29 and Resident#19 families were notified of transfers via telephone. As of 1.28.2025, both residents have been discharged from the facility.The social services director was educated on sending the NC transfer/discharge form to families/residents when they are transferred or discharged to other facilities. This education was provided by the administrator on 12/20/2024. 2. An audit of all resident discharges and or transfers that occurred between 1.8.2025 through 2.6.2025 was completed on 2.6.2025. A NC transfer/discharge form was sent by mail to all by the Social Worker Director by 2/10/2025. 3. Staff Development Coordinator/Designee provided education to Licensed Nurses, Social Services, and Business Office on requirements of Notice of Transfer. Education to be completed on or by 2/10/2025. Newly Hired Licensed Nurses and Social Services will be educated on Notice of Transfer during department orientation by the Staff Development Coordinator/Designee 4. The DON / Designee will complete audits of resident transfers to ensure Notice of transfer was provided to the resident/RP	

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F 623	Continued From page 34 Resident #29 and her representative were interviewed on 12/16/24 at 3:53 PM. The representative reported she had not received a written notification of transfer from the facility for any hospitalization for Resident #29. Resident #29 reported she had not received a written notification of transfer for any hospitalization. The Social Worker (SW) was interviewed on 12/19/24 at 2:38 PM. The SW reported she did not know who was responsible for the letters of transfer, but she had not completed the notifications for any residents. The Administrator was interviewed on 12/19/24 at 4:19 pm. The Administrator explained the SW should be completing the transfer notifications for hospitalization when a resident was admitted to the hospital, and he did not know why she was not doing the transfer notifications. The Administrator reported he expected all residents or their representatives to receive a written notification of transfer for any hospital admissions. 2. Resident #19 was admitted to the facility 10/13/22. The most recent quarterly Minimum Data Set assessment dated 11/28/24 documented Resident #19 was severely cognitively impaired. A nursing note dated 4/3/24 documented Resident #19 was sent to the hospital for evaluation due to a change in condition. Review of the medical record for Resident #19 revealed no written notification of transfer.	F 623	3x week x 4 weeks, then 2x week x 4 weeks, then 1x week for 4 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Nursing Home Administrator monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 2/10/2025	

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F 623	Continued From page 35 A nursing note dated 4/8/24 documented Resident #19 was readmitted to the facility. Resident #19's representative was not available for interview. The Social Worker (SW) was interviewed on 12/19/24 at 2:38 PM. The SW reported she did not know who was responsible for the letters of transfer, but she had not completed the written notifications for any residents. The Administrator was interviewed on 12/19/24 at 4:19 pm. The Administrator explained the SW should be completing the transfer notifications for hospitalization when a resident was admitted to the hospital, and he did not know why she was not doing the transfer notifications. The Administrator reported he expected all residents or their representatives to receive a written notification of transfer for any hospital admissions.	F 623		
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 staff interviews, the facility failed to administer amantadine (a medication used for involuntary muscle movements or shaking) for 1 of 5 residents observed with medications at the bedside (Resident #110).	F 658	F658 Services Provided Meet Professional Standards 1. The Amantadine was removed from Resident#110 bedside and discarded by	2/10/25

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F 658	Continued From page 36 The findings included: Resident #110 was admitted to the facility 7/16/24 with diagnoses including nontraumatic intracerebral hemorrhage (stroke), and hypertension. A physician order dated 8/3/24 for amantadine 50 milligrams per 5 milliliters was ordered to administer 20 milliliters by mouth three times per day. The significant change Minimum Data Set assessment dated 11/8/24 documented Resident #110 was severely cognitively impaired. Review of Resident #110's medical record revealed no physician order to self-administer medications. Resident #110 was observed on 12/16/24 at 11:14 AM sitting in his reclining chair. The bedside table was in front of him and a medication cup had 20 milliliters of clear liquid. Resident #110 was asked what was in the medication cup and he reported "my medication". Nurse #1 was interviewed on 12/16/24 at 11:16 AM. Nurse #1 reported she had administered medications to Resident #110 "a few minutes ago". When she was informed a cup of clear liquid was found on his bedside table, she reported that the medication was amantadine, and she had forgotten to administer it to Resident #110. Nurse #1 was interviewed again on 12/16/24 at 11:20 AM and she confirmed that when she went	F 658	Nurse #1. Nurse #1 administrated Amantadine per physician order on 12/16/24. 1:1 education the Director of Nursing provided with Nurse # 1 regarding administration of medication per physician orders, include that medication are not be left at bedside. 2. On 12/30/24 The Director of Nursing /designee completed Audit of all resident rooms to ensure medications where not being left at the bedside . No medications at the bedside were identified. 3. The Staff Development Coordinator /designee will provided education to licensed nurses regarding leaving medications at the bedside. The education will be completed by 2/10/25. Newly hired licensed nurses will receive the education during newly hired orientation. Licensed Nurses including agency staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this education by the Director of Nursing/designee. 4. The Director of Nursing /designee will audit the 10 resident rooms three times a week for four weeks, then two times a week for four weeks, then one time week to ensure medications are not at the	

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F 658	Continued From page 37 to Resident #110's room to administer medications, she had set the amantadine in the medication cup down on the bedside table to administer his other medications and had forgotten the amantadine. The Director of Nursing (DON) was interviewed on 12/16/24 at 4:42 PM. The DON explained that Nurse #1 was training and had set the medication down to administer other medications and had forgotten the amantadine. The DON reported no medication should be left at any resident's bedside and the nurse should administer all medications before leaving the room. The Nurse Practitioner (NP) was interviewed on 12/18/24 at 12:29 PM. The NP reported Resident #110 was not capable of administering his own medications. The NP reported if Resident #110 had missed the amantadine it would not have been a significant medication error because he received the medication three times per day.	F 658	bedside. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QAA) Committee by the Director of Nursing monthly x 3 months. At that time, the QAA committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 2.10.2025	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		2/10/25

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F 693	Continued From page 38 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to store a tube feeding syringe with the plunger separated from the syringe for 1 of 4 residents (Resident #95) reviewed for enteral feeding management, which created a potential for bacterial growth. Findings included: Resident #95 was admitted to the facility on 8/1/2023 with diagnoses of stroke and difficulty swallowing. A review of Resident #95's Physician's Orders revealed an order for 150 milliliter water flushes five times a day (order was written on 9/9/2024); an order for 60 milliliter water flushes before and after her tube feedings every 12 hours (order was written on 9/9/2024); and an order for tube feedings to infuse at 65 milliliters per hour to begin at 8:00 pm and end at 8:00 am daily (order was written 9/9/2024). An annual Minimum Data Set assessment dated 10/9/2024 indicated Resident #95 was severely cognitively impaired, received 51% or more of her total calories from tube feedings, and had no weight loss.	F 693	F693 Tube Feeding Mgmt /Restore Eating Skills 1. Resident #95 tubing feeding syringe was replaced on 12/18/24 by the Director of Nursing and properly separated. Nurse #3 was provided 1:1 education on 12/18/24 by the Director of Nursing regarding storage of tubing feeding syringe that included separating the plunger after use. 2. The Director of Nursing /designee will complete Audit of resident requiring enteral feeding management to ensure that feeding syringes are properly stored, to include plunger separated after use . Those not stored correctly will be discarded and new ones provided. The audit will be completed by 2/10/25. 3. The Staff Development Coordinator /designee will provide education regarding proper storage of tube feeding syringes,	

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F 693	Continued From page 39 On 12/17/2024 at 8:57 am during an observation of Resident #95 in her room a tube feeding syringe was observed in a plastic bag hanging from Resident #95's tube feeding pole with the plunger inside the syringe and clear liquid in the tip of the syringe. On 12/18/2024 at 1:32 pm an observation was made of Resident #95 in her room with the tube feeding syringe in a plastic bag hanging from the tube feeding pole with the plunger inside the syringe and clear liquid in the tip of the syringe. Nurse #3 was interviewed on 12/18/2024 at 1:36 pm and she stated Resident #95 received 150 milliliter water flushes to her gastrostomy tube every four hours and she flushed her gastrostomy tube at 12:00 pm. Nurse #3 stated the tube feeding syringes are placed in a plastic bag hanging from the tube feeding pole after each flush and she was not aware she should separate the plunger from the syringe and allow it to dry to prevent bacteria in the syringe. On 12/19/2024 at 3:02 pm the Director of Nursing was interviewed, and she stated she expected the nurses to store the plunger separate from the tube feeding syringe to prevent any residue that may cause bacteria. The Administrator was interviewed on 12/19/2024 at 3:33 pm and he stated he did not feel qualified to make a statement regarding the feeding tube syringe being left in the syringe, but the nurse should follow protocol for how the syringe should be stored to prevent bacteria in the syringe.	F 693	that include storing the plunger separate after use. The education will be completed by 2/10/25. Newly hired licensed nurses will receive the education during new hire orientation. Any licensed Nurse including agency staff that cannot be reached within the initial education time frame will not take an assignment until they have received this education by the Director of Nursing/designee. 4. The Director of Nursing /designee will complete audits of residents requiring enteral feeding management to ensure that feeding syringes are properly stored, to include plunger separated after use. The audits will be completed three times a week for four weeks, then two times a week for four weeks, then one time a week for four weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QAA) Committee by the Nursing Home Administrator monthly times three months. The QAA committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of compliance: 2.10.2025	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		2/10/25

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F 761	Continued From page 40 §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. §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, staff interviews, and record review, the facility failed to label a medication stored on 1 of 7 medication carts (3W medication cart) and failed to remove expired medications on 2 of 7 medication carts (3W and 3E medication cart). The findings included: 1a. An observation on 12/19/2024 at 3W medication cart at 10:38 am with the presence of	F 761	F761 Label/Store Drug and Biologicals 1. The Lantus Solostar labeled with an open date of 12.16.24, the Lispro with an open date of 7.19.24, the Novolog 100 units/ml with no date of opening, an insulin, glargine injector with an open date of 10/7/2024, and an Albuterol sulfate nebulizer 0.63/3ml with an open date of 10/31/2024 were all removed from the	

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F 761	Continued From page 41 Nurse #5. The following items were found in this medication cart: a. A Lantus Solostar with an open date of 12/16/24 was stored on the med cart. Neither the insulin pen itself nor the medication pen it was stored in was labeled with the minimum information required, including the name of the resident the insulin had been dispensed for. b. An Insulin lispro with an open date of 7/19/24 was stored on the med cart. The manufacturer recommendation was to be discarded after 28 days of opening. c. A Novolog 100 units/ml vial was open with no date of opening and was stored on the med cart. It was noted the medication was delivered by the pharmacy on 4/28/24. The manufacturer recommendation was to be discarded after 28 days of opening. d. An Insulin glargine injector with an open date of 10/7/24 was stored on the med cart. The manufacturer recommendation was to be discarded after 28 days of opening. e. An Albuterol sulfate nebulizer 0.63/3ml opened on 10/31/24 was stored on the med cart. The manufacturer recommended to discard unused vials 2 weeks after opening the foil packaging. Interview with Nurse #5 on 12/19/2024 at 10:47 am she stated that all nurses were all responsible for checking the medication carts and the Unit Managers were to check every month. Nurse #5 confirmed that there was no resident's name on the opened Lantus Solostar, and she didn't know what happened to the label.	F 761	medication carts on 12.19.2024 and discarded by the Director of Nursing. 2. On 1/24/25 the Director of Nursing /designee completed audit of medication carts on 100, 200 west, 200 central, 200 east, 300 west, 300 central and 300 east to ensure that Drugs / Biologicals were label and stored properly. No observation of incorrect storage / labeling of medication /biologicals were identified. 3. Licensed Nursing will be provided education by Staff Development Coordinator /designee regarding labeling/storage of Drug and Biologicals. The education will be completed by 2/10/25. Newly hired licensed nurses will receive the education regarding labeling/storage of Drugs/Biologicals during orientation. Licensed Nurse including agency staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this education by the Director of Nursing/designee. 4. The Director of Nursing /designee will complete audit of all medication carts to ensure that medication/Biologicals are labeled and stored properly. The audits will be completed three times a week for four weeks, then two times a week for	

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F 761	Continued From page 42 1b. An observation on 3E medication cart on 12/19/24 at 10:51 am with the presence of Nurse #4. A CO Q-10 50 multidose bottle with an expiration date of 10/24/24 was located on top of the medication cart. Interview with Nurse #4 on 12/19/2024 at 11:09 am stated that the Unit Manager checked the medication carts, and all nurses are responsible to make sure all out of date meds were removed. Interview with the Director of Nursing (DON) on 12/19/24 at 11:11 am. The DON stated that the nurses on the medication carts should check the medication cart and get rid of expired medication. The DON stated that all medication should have a label including the resident's name and the other labeling information printed from the pharmacy. She stated that the pharmacy checked the medication carts and medication rooms every month. She further stated that the Unit Manager spot checked the medication cart for expired medication. Interview with the Administrator on 12/19/24 01:57 PM stated that the nurses were responsible for checking the medication carts every day and they were supposed to discard any expired medication.	F 761	four weeks, then one time a week for four weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QAA) Committee by the Director of Nursing monthly x 3 months. At that time, the QAA committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of compliance: 2.10.2025	
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 925		2/10/25

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F 925	Continued From page 43 Based on record review, staff interviews, and observations the facility failed to provide an environment free of pests for 3 of 23 resident rooms (Resident #80, Resident #26, and Resident #86) and 1 of 3 community restrooms observed for roaches. Findings included: a. A quarterly Minimum Data Set assessment dated 10/11/2024 indicated Resident #80 was cognitively intact. During an observation of the 100-hall on 12/18/2024 at 10:00 am two dead roaches were observed in Resident #80's room (room 134). One roach was approximately 5 cm long and was a dark brown color and the other was approximately 2 centimeters long and was a light brown color. The roaches were observed in the floor near Resident #80's closet. Resident #80 was interviewed on 12/18/2024 at 10:00 am and stated she killed the roaches in her room and the roaches came out more at night and get on her bed and crawl on her. She stated it is very upsetting when they get on her at night. Nurse Aide #4 was interviewed on 12/18/2024 at 10:43 am and she stated she sees roaches in the building once or twice a week. She stated the roaches are worse on the 100-hall than on the other halls and the facility does have a pest control company come frequently to spray for the roaches, but it does not do much good. She stated she had reported roaches to the Maintenance Director. b. A quarterly Minimum Data Set assessment	F 925	F925 Pest Control Maintains Effective Pest Control Program 1. On 12/30/24 EcoLab Pest Control provided treatment to all residents rooms which included Resident Room #80, #26, and #86 and community restrooms. 2. On 12/24/24 the Vice President of Operation /administrator completed audit of all resident room and community restrooms to ensure there were no visible signs of pest. No rooms were identified as having evidence of pest. 3. Education was provided by the Staff Development Coordinator/Desginee to all staff regarding reporting and maintaining a pest free environment. The education will be completed by 2/10/25. Newly hired Center Staff will be educated on reporting and maintaining a pest free environment during general orientation by the Staff Development Coordinator/Designee. Facility Staff including agency staff that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this education by the Director of Nursing/designee. 4. The Nursing Home	

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F 925	Continued From page 44 dated 11/13/2024 indicated resident #26 was cognitively intact. An interview was conducted with Resident #26, who resided in room 341, on 12/18/2024 at 8:55 am and she stated she observes roaches in her room occasionally. She stated they are usually on the floor in her room. c. A quarterly Minimum Data Set assessment dated 10/5/2024 indicated Resident #86 was cognitively intact. During an observation and interview with Resident #86, who resided in room 133, on 12/18/2024 at 10:00 am she stated she has seen roaches in her bathroom frequently and she stated some are really big and some are small. d. On 12/16/2024 at 11:00 am a live roach was observed on the 300-hall in the restroom. The roach was approximately 2 inches long and ran when the bathroom light was turned on. Review of the facility's Pest Control Reports from 7/8/2024 to 11/30/2024 indicated no pest activity was observed during the monthly pest treatments. The Maintenance Director was interviewed on 12/18/2024 at 2:57 pm and stated the pest control company comes monthly and if someone reports they see a roach he has them come immediately to treat for roaches. The Maintenance Director stated roaches do come in and out of the facility, but the facility was not infested with roaches. On 12/18/2024 at 3:00 pm the Administrator stated the facility is treated monthly for pests and when anyone sees roaches they immediately treat. He stated he was not aware of resident	F 925	Administrator/designee will complete audit of 10 resident rooms and common areas to ensure that there is no visible evidence of pest. The audits will be completed three times a week for four weeks, then two times a week for four weeks, then one time a week for four weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QAA) Committee by the Nursing Home Administrator monthly x 3 months. At that time, the QAA committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance:2/10/2025	

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F 925	Continued From page 45 complaints regarding roaches in their rooms recently.	F 925		