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	345344	A. BUILDING _____ B. WING _____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELLIA GARDENS CENTER FOR NURSING AND REHAB	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(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 000	INITIAL COMMENTS A complaint investigation was conducted from 2/13/2025 to 2/14/2025 onsite. Additional information was obtained offsite on 2/17/2025, 2/18/2025, and 2/19/2025. Therefore, the exit date was 2/19/2025. Event ID # M0UL11. The following intakes were investigated NC00227594, NC00226830, NC00226733, NC00226647, NC00226012, NC00224549, NC00224141, NC00223921, and NC00223910. Eleven of the fourteen allegations resulted in a deficiency.	F 000		
F 550 SS=G	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 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.	F 550		3/13/25

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

Electronically Signed | 03/08/2025

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F 550	Continued From page 1 §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 record review, and resident and staff interviews, the facility failed to provide services with dignity and respect for 2 (Resident #1 and Resident #3) of 4 residents reviewed for dignity. A reasonable person would be traumatized by having a nurse aide expose herself, intentionally pass gas nearby, and laugh at their expense. Findings included: Resident #3 was admitted to the facility on 3/29/2023 and had cumulative diagnoses some of which included schizophrenia, chronic pain syndrome, aphasia, major depressive disorder, and adjustment disorder with anxiety. Documentation on a quarterly Minimum Data Set (MDS) assessment dated 1/10/2025 revealed Resident #3 had severely impaired cognition with physical behaviors 1 to 3 days of the assessment period and with verbal behaviors 4 to 6 days of	F 550	Residents #1 and 3 continue to reside in the facility and remain in stable condition. Residents residing in the facility have the potential to be affected by the deficient practice. On 3/1/2025 the Regional Director of Clinical Services (RDCS) completed an audit of progress notes for the past 14 days to ensure there is no documentation reflective of a resident with combative/aggressive behavior approached with inappropriate staff behaviors. On 3/5/2025 the Social Service (SS) completed interviews with alert and oriented residents with Brief Interview of Mental Status (BIMS) of 12 and greater to ensure no resident has experienced or witnessed inappropriate staff behavior in	

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F 550	Continued From page 2	F 550		

the assessment period. Resident #3 was assessed as rejecting of care 4 to 6 days of the assessment period. Resident #3 was evaluated as dependent on staff for personal hygiene and required substantial assistance from staff for transfers.

Resident #3 had a care plan, dated as last reviewed on 1/13/2025, with a focus area for verbally aggressive behavior relative to mental emotional illness and calling staff inappropriate names, and racial slurs toward other residents and staff. Some of the interventions included when Resident #3 became agitated: intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation, if the response was aggressive, staff to walk calmly away and approach later.

Documentation in a nursing progress note written by Nurse #2 on 1/15/2025 at 9:00 PM revealed, "Resident (Resident #3) refused to allow staff to give incontinent care this shift; he sat in his wheelchair in hall and cursed at staff using racial slurs several times; spoke to resident about getting incontinent care and behavior; he stated he didn't need changing and wanted everyone to leave him alone even though he was shown he was very wet by pointing out clothing to him; [10:40 PM] resident was asked to receive incontinent care he refused at end of shift."

Resident #1 was admitted to the facility on 7/19/2024. Documentation on a quarterly MDS assessment dated 12/20/2025 revealed Resident #1 was assessed as cognitively intact.

Resident #1 was interviewed on 2/13/2025 at 12:50 PM. Resident #1 revealed the following

the prior seven (7) days. No concerns were identified.

On 3/4/2025 the Staff Development Coordinator (SDC) initiated education with staff regarding customer service, caring for a combative/aggressive resident, staff burn-out, inappropriate behaviors, and effective communication, as well as questioned staff to ensure no staff have been witness to staff inappropriate behavior. Education was completed by 3/7/2025. After 3/7/2025 staff who were not educated will be educated by the Staff Development Coordinator (SDC) prior to beginning their next scheduled shift. Newly hired staff will be educated by the SDC during orientation.

The Unit Manager (UM), SDC, and/or Nursing Home Administrator (NHA) will observe 5 staff to resident interactions weekly for 12 weeks, on varied shifts, to ensure staff are interacting with residents appropriately and that customer service is always in the forefront.

The NHA will forward the results of audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly x3 months. The QAPI Committee will review the staff to resident interaction audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.

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events as happening at the change of shift at approximately 11:00 PM on 1/15/2025. Resident #1 heard from her room, Resident #3 repeatedly saying "Leave me alone. Leave me alone" and cursing loudly. From her room Resident #1 could see Resident #3 was sitting in his wheelchair near the nursing desk outside of her room. Approximately six nurse aides were standing around the nursing desk and laughing because Nurse Aide (NA) #3 was dancing around Resident #3 in front of him with her pants pulled down sticking her buttocks in his face. Resident #1 grabbed her ice pitcher, got in her wheelchair, and went into the hallway to see what was happening to Resident #3. Resident #3 kept hollering out, "Leave me alone. Leave me alone." NA #3 then turned around and pulled her pants down in the front exposing herself to Resident #3 putting her body right up to his face. Resident #1 stated all the nursing staff were laughing at Resident #3. NA #3 then went around behind Resident #3 pulled down her pants in the back, stuck her buttocks on his back, and passed gas on him. Resident #1 explained that she knew Resident #3 had "issues." Resident #1 thought she needed to distract NA #3 to make her leave Resident #3 alone, so she asked NA #3 to get her some ice for her water pitcher. NA #3 told her, "I'm not getting no [curse] ice, I'm going home." Resident #1 explained the event did not make her feel good and stated, "Nobody should be treated like that." Resident #1 explained the next day she reported the incident during her therapy session.

The Rehabilitation Director was interviewed on 2/13/2025 at 2:36 PM. The Rehabilitation Director provided the following information. The Rehabilitation Director confirmed that Resident #1 had reported to her during her therapy session on

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1/16/2025 the events of the previous evening with Resident #3 and NA #3. The Rehabilitation Director stated she immediately went to inform the Director of Nursing in person of the concerns reported by Resident #1. In addition, the Rehabilitation Director filled out a grievance form on behalf of Resident #1 and emailed it to the Administrator and Social Services Director that same day.

NA #2 was interviewed on 2/13/2025 at 3:25 PM. NA #2 confirmed she worked on 1/15/2025 on the 3:00 PM to 11:00 PM shift. NA #2 indicated on 1/15/2025 at 11:00 PM both the second shift (3:00 PM to 11:00 PM) remained and the third shift (11:00 PM to 7:00 AM) was arriving. NA #2 explained Resident #3 was in the hallway near the nurses' desk cussing and hollering at NA #3. NA #3 turned around and exposed her buttocks and her front perineal area to Resident #3 and then walked away. NA #2 confirmed the nursing staff at the nurses' desk were laughing. NA #2 stated she was not able to recollect accurately which nurse aides and nurses were witnesses to the actions of NA #3 but, she thought Nurse #2, NA #4, NA #5, and NA #6 were all witnesses. NA #2 stated that everything was caught on a camera in the hallway. NA #2 requested that her name not be documented for the interview out of fear for losing her job.

NA #4 was interviewed on 2/13/2025 at 4:25 PM. NA #4 confirmed she was working at the facility on the shift beginning on 1/15/2025 at 11:00 PM until 1/16/2025 at 7:00 AM. NA #4 confirmed she was at the nurses' desk when NA #3 pulled down her pants exposing her buttocks and front perineal area to Resident #3 after he called her a racial slur. NA #4 confirmed that all the staff at the

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F 550	Continued From page 5 nurses' desk were laughing at NA #3 and Resident #3. NA #4 explained that nobody spoke up or intervened because nobody wanted to offend another nurse aide or nurse because it would make it difficult to work together again if someone corrected NA #3. NA #5 was interviewed on 2/14/2025 at 9:11AM. NA #5 revealed she observed NA #3 attempting to put Resident #3 to bed, but he wanted to go smoke. NA #5 indicated Resident #3 was calling NA #3 derogatory names, but the screaming and hollering was "too much for her nerves" so she went down the hallway without witnessing anything else. Requests for interviews with NA #3, NA #6, and Nurse #2 were not responded to. The facility Administrator was interviewed on 2/13/2025 at 3:05 PM. The Administrator stated NA #3 was suspended and then terminated for her lack of customer service and inappropriate behavior. The Administrator stated there were not six witnesses to the incident. The Administrator was interviewed again on 2/14/2024 at 10:45 AM. He stated that, as a company directive, there were no cameras in the building and no camera footage. The Administrator revealed that the facility was trying to get rid of Resident #3 because he was racist and vulgar to staff.	F 550		
F 584 SS=D	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,	F 584		3/13/25

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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;

§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:

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F 584	Continued From page 7 Based on observation, staff interviews, and resident interviews, the facility failed to provide comfortable room temperatures for one (Resident #16) of three residents reviewed for comfortable room temperatures. Findings included: Documentation on a quarterly Minimum Data Set assessment dated 1/14/2025 revealed Resident #16 was coded as cognitively intact. An interview was conducted with Resident #16 on 2/13/2025 at 12:56 PM. Resident #16 stated the facility had been without heat for the rooms in the front of the building for three weeks. Resident #16 explained a big heater was placed in the hallway and space heaters in each of the residents' rooms. Resident #16 further explained that when everybody turned on their space heaters to keep warm, the circuit breaker would trip, and a staff member had to go into the Director of Nursing's office and reset the circuit breaker. Resident #16 stated that at night the staff did not have access to the Director of Nursing's office and was often unable to reset the circuit breaker. Resident #16 stated he did not want his door open at night due to the noise from the big heater in the hallway and the television area close to his room. Resident #16 stated it was so cold at night that he had to wear a thick hoodie and multiple blankets, and even then, he could not get warm enough. The facility Administrator was interviewed on 2/13/2025 at 1:35 PM. The Administrator explained a part had to be manufactured to fix the outside heating and air conditioning unit. The Administrator explained the facility had put an industrial heater in the hallway and individual space heaters in each resident's room. The Administrator stated that if the residents in the	F 584	Resident #16 continues to reside in the facility and remains in stable condition. Resident #16 has no current complaints about room temperature. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 3/4/2025 the Maintenance Director initiated an audit to ensure resident rooms maintain a comfortable temperature. The audit was completed at varied times of the day to include evening hours. The audit was completed by 3/7/2025. Areas of concern will be addressed by the Maintenance Director. On 3/4/2025 the Regional Director of Special Operations completed an inservice with the maintenance department regarding maintaining a comfortable temperature in resident rooms. Newly hired Maintenance personnel will be educated by the Staff Development Coordinator (SDC) during orientation. The Maintenance Director or Assistant will complete an audit one (1) time a day, three (3) days a week for 12 weeks to ensure resident rooms, to include rooms at the front of the facility, maintain comfortable temperatures. The audit will be completed at varied times of the day to include evening hours. Temperatures will be entered in the TELS system Any areas of concern will be addressed by the maintenance department.	

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F 584	Continued From page 8 affected rooms kept their doors open, then the rooms would stay heated. The Administrator added that if the circuit breaker tripped, a staff member would reset the breaker located in the Director of Nursing's office. The Administrator was unaware of staff members not resetting the breaker at night. Interviews and observations were made in Resident #16's room on 2/14/2025 at 7:05 AM. Resident #16 stated his room was too cold this morning and he complained when he had to do self-catheterization, he needed to have the door closed for privacy. Resident #16 demonstrated how the space heater in his room, the adjustable bed, and the television were not working because the circuit breaker was tripped. Resident #16 stated he just wanted to get in bed and wrap up due to the cold temperature in the room, but nothing worked. An interview and observation were conducted with the Maintenance Director on 2/14/2025 at 7:20 AM in Resident #16's room. The Maintenance Director stated that it was his second week working at the facility. He explained the heating and air conditioning unit outside was broken and a part needed to be made. The Maintenance Director was asked if he had a way of measuring the room temperature. The Maintenance Director stated he had a digital thermometer to measure the air temperature. The Maintenance Director removed the sheath from a digital thermometer and held up the thermometer up in the air in the middle of the room with the door open. The room temperature was 73 degrees Fahrenheit in the room on the digital thermometer. The Maintenance Director acknowledged the room temperature did not feel	F 584	The Maintenance Director will forward the results of audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will review the temperature audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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like 73 degrees Fahrenheit. The Maintenance Director indicated the hallway heater would heat Resident #16's room if he left the door open.

An additional interview was conducted with the facility Maintenance Director on 2/14/2025 at 11:55 AM. The facility Maintenance Director stated he was permitted to purchase a laser thermometer to measure the air temperatures. The Maintenance Director stated the temperature in Resident #16's room was 71.8 degrees Fahrenheit with the door open. The Maintenance Director did not know what the room temperatures were at night.

The Administrator was interviewed on 2/14/2025 at 10:45 AM. The Administrator confirmed the current Maintenance Director had started on 2/3/2025 and would not provide the contact information for the previous Maintenance Director.

The Director of Plant Operations was interviewed on 2/18/2025 at 8:38 AM and the following information was provided. On 1/19/2025 the facility reported having issues with the heat exchanger on the outside heating and air conditioning unit. On 1/20/2025 contractors unsuccessfully attempted to fix the heat exchanger. A new part will be manufactured at the factory within 30 days. On 1/21/2025 the six rooms that contained residents received space heaters and a large electric heater was put in the hallway.

The facility provided documentation on a typed spreadsheet that listed room temperatures, dates, and hallway temperatures. The spreadsheet was entitled, "Temp Log for Rooms

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F 584	Continued From page 10 101 to 106." The log listed a daily room temperature and a hall temperature from 1/27/2025 to 2/19/2025. The lowest room temperature listed on the spreadsheet was 71 degrees Fahrenheit and the lowest hallway temperature listed was 72 degrees Fahrenheit. There was no documentation of the time of day, the exact location of the temperature, or who took the temperatures on the spreadsheet.	F 584		
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: Based on observations, record review, and staff interviews, the facility failed to prevent physical and verbal abuse from staff for one (Resident #4) of three residents reviewed for physical and verbal abuse. Findings included: On 2/13/2025 at 10:55 AM the Director of Nursing (DON) provided a list of alert and oriented residents which included Resident #10 and did	F 600	Resident #4 continues to reside in the facility and remains in stable condition. On 3/1/2025 the Director of Nursing (DON) was educated by the Regional Director of Clinical Services regarding abuse, what constitutes abuse, and stepping away from a resident whose behaviors are escalating. The DON has been suspended.	3/13/25

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F 600	Continued From page 11 not include Resident #4 or Resident #3. Resident #4 was admitted to the facility on 4/12/2023 with diagnoses of C5-C7 vertebrae incomplete quadriplegia, adjustment disorder with mixed disturbance of emotions and conduct, post-traumatic stress disorder, scoliosis, and major depressive disorder. (C5-C7 incomplete quadriplegia refers to a spinal cord injury at the C5 to C7 vertebrae in the neck, resulting in paralysis affecting all four limbs due to damage to the nerves controlling movement in that area.) Documentation on a quarterly Minimum Data Set (MDS) assessment dated 12/10/2024 revealed Resident #4 was cognitively intact with verbal behaviors one to three days of the assessment period. Documentation on the care plan for Resident #4, dated as last reviewed on 12/16/2024 revealed a focus area for "[Resident #4] has verbally aggressive-verbal threats, cursing at staff and other residents relative to mental/emotional illness, poor impulse control" and "[Resident #4] has potential to be physically aggressive relative to anger, post-traumatic stress disorder diagnosis." Both focus areas had the intervention, "When the resident becomes agitated: intervene before agitation escalates; guide away from the source of distress; engage calmly in conversation; if the response is aggressive, staff to walk away calmly, and approach later." Resident #4 was interviewed on 2/13/2025 at 11:05 AM and she revealed the following information. Resident #4 revealed on 1/3/2025 she argued with Resident #3 earlier in the day. Around lunchtime, Resident #4, Resident #3, and	F 600	Residents residing in the facility have the potential to be affected by the deficient practice. On 3/1/2025 the Regional Director of Clinical Services (RDCS) completed a review of progress notes from the past 14 days to ensure no documentation exists that may be construed as abuse. RDCS reviewed the past 30 days grievances to ensure no grievance could rise to potential abuse. No concerns identified. On 3/5/2025 the Social Worker (SW) completed interviews with residents who are alert and oriented, scoring 12 and greater on Brief Interview of Mental Status (BIMS) to ensure no residents have experienced or witnessed abuse in the past 7 days to include Resident #4. Wound nurse and ADON completed skin assessments on cognitively impaired residents whose BIMS is 11 and lower to ensure no new skin impairments were identified that would indicate potential abuse. No concerns identified. On 3/4/2025 Staff Development Coordinator (SDC) initiated education with staff regarding abuse, to include the Director of Nursing (DON). Education included the definition of abuse, who to report abuse to, what constitutes abuse, and freedom from retaliation when reporting an occurrence. Education was completed by 3/7/2025. After 3/7/2025 staff who were not educated will be educated by the Staff Development Coordinator (SDC) prior to starting their	

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F 600	Continued From page 12 Resident #10 were in the hallway getting ready to go out to smoke. Resident #3 was cussing at Resident #4 and Resident #4 was cussing at Resident #3. The Director of Nursing (DON) and Nurse Aide (NA) #1 took all three of the residents, Resident #3, Resident #4, and Resident #10, outside to go to smoke cigarettes. Resident #3 continued to cuss and threaten Resident #4, and Resident #4 was cussing back at him as they sat smoking. The DON told Resident #4 to be quiet. Resident #4 explained she felt like the DON was only telling her to be quiet while Resident #3 was allowed to sit and swear at her. Resident #4 revealed she told the DON she was not going to tell her to "shut her mouth." Resident #4 revealed she did call the DON a "[female dog]" and '[racial slur]", and the DON began to argue with her. Resident #4 stated she moved her wheelchair forward toward the DON and the DON shoved her and hit her. Resident #4 revealed the DON began to shout at her and Resident #4 screamed out that the DON hit her. NA #1 just stood there. The DON then fled into the building. Resident #4 called the police, and they came to the facility. Resident #4 indicated the police told her she would have to go to the police station to make a report. Resident #4 also called local Adult Protective Services and the state long-term care complaint line. Resident #4 said the DON was suspended but then returned to the facility in a few days as if nothing happened. A photograph, dated 1/3/2025, was observed on the telephone of Resident #4 depicting a visible bruise on the left side of her face near her chin. Resident #4 explained she showed the picture to the Administrator and to the facility Social Worker. An additional photograph was observed on the phone of Resident #4, of a note from Resident #10 dated 1/3/2025 explaining Resident #10 was	F 600	next shift. Newly hired staff will be educated by the SDC during orientation. The Unit Manager (UM), Nursing Home Administrator (NHA), and/or SDC will conduct 10 audits a week for 12 weeks observing staff interaction with residents to ensure staff interact with residents in a calm, respectful manner, and steps away from an escalating situation, if needed. The Nursing Home Administrator (NHA) will review audits weekly. The NHA will forward the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review the staff to resident interaction audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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a witness to the altercation. On the evening of 1/29/2025 Resident #4's electric wheelchair was taken from her with the pretense she had hit someone with the wheelchair, but she was not told who. Resident #4 felt the removal of her wheelchair was in retaliation for her calling adult protective services, who opened an investigation.

There was no documentation in the medical record of Resident #4 using her wheelchair to run into staff or residents in January 2025.

On 2/13/2025 at 12:45 PM, the DON requested that Resident #10 be removed from the list of residents deemed alert and oriented.

Resident #10 was admitted to the facility on 2/5/2024 and has diagnoses of adjustment disorder with mixed disturbance of emotions and conduct as well as anxiety disorder.

Documentation on a care plan dated as last reviewed on 1/22/2025 for Resident #10 revealed she had a focus area for a behavior problem related to anxiety as well as episodes of fabrication.

Documentation on a recent Brief Interview for Mental Status dated 2/5/2025, Resident #10 scored 15 out of 15, indicating she was cognitively intact.

An interview was conducted with the facility Psychiatric Mental Health Nurse Practitioner (PMHNP) #1 on 2/19/2025 at 11:42 AM. PMHNP #1 indicated he saw Resident #10 weekly and provided the following insight into the reliability of the information provided by Resident #10. PMHNP #1 confirmed Resident #10 had anxiety

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and very negative thoughts. PMHNP #1 thought Resident #10 complained about the facility services and was unrealistic about her complaints. In addition, PMHNP #1 thought Resident #10 could be manipulative, telling people what they wanted to hear.

Resident #10 was interviewed on 2/17/2025 at 5:55 PM. Resident #10 related the following events as occurring on 1/3/2025. Resident #10, Resident #3, and Resident #4 were in the hallway. Resident #3 and Resident #4 were arguing. Resident #10 stated, "It was a big thing." Resident #10 indicated a nurse aide (NA #1), and a nurse (DON) took the three residents, Resident #10, Resident #3, and Resident #4, outside to smoke cigarettes. Resident #10 stated she sat in her usual spot in the smoking area with a full view of the building door and the smoking area. Resident #3 and Resident #4 continued to argue then Resident #4 and the nurse (DON) started to argue. Resident #4 did not run her wheelchair into the nurse (DON). The nurse (DON) acted like she wanted to fight Resident #4 and pushed Resident #4. Resident #10 confirmed the nurse (DON) did not slap or hit Resident #4 but pushed her. After that, Resident #4 was very upset. The nurse (DON) acted like she wanted to beat Resident #4 up. The nurse aide (NA #1) stopped the nurse (DON) and pulled her away. The nurse aide (NA #1) laughed like the whole thing was funny. The nurse aide (NA #1) tried to break them up and the nurse went back into the building. Resident #10 and Resident #4 also went back into the building. Resident #10 stated that nobody had asked her what had happened except for the police. Resident #10 added that other residents had asked her what had happened, but she did not tell them because she did not gossip. Resident

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#10 revealed the police told her the nurse (DON) had the right to defend herself. The nurse aide (NA #1) saw everything that happened that day.

NA #1 was interviewed on 2/13/2025 at 1:03 PM and provided the following information. NA #1 stated Resident #3 and Resident #4 were fussing in the hallway. The DON was trying to calm Resident #4 down. The DON and NA #1 took Resident #4, Resident #10, and Resident #3 outside through the side door to smoke in the smoking area. Resident #4 "put her wheelchair in drive" and hit the DON with her wheelchair. The DON turned around and went back into the building. The DON did not do anything. The DON did nothing wrong.

The DON was interviewed on 2/14/2025 at 7:25 AM. The DON described the following events and made the following statements. Resident #3 and Resident #4 were always "getting into it, cursing and hollering." The DON came out of her office and told Resident #3 and Resident #4 to "keep it down." The DON described the scene as "chaos" with visitors and a new resident in the hallway working with therapy. The DON stated she knew it had to stop. The DON stated she was trying to move Resident #3 away from Resident #4, but the two residents would not stop. The DON stated she took the residents out the back door with the help of NA #1 to the smoking area. Resident #4 would not stop swearing and kept on talking. The DON stated she told Resident #4 to be quiet. Resident #4 responded to the DON telling her, "You can't tell me what to do." The DON turned to walk away from the table area. Resident #4 brought her wheelchair close to the DON and was getting mad. Resident #4 called the DON a "Black [racial slur] [female dog]." The DON stated

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she told Resident #4 to be quiet and the DON walked to the door of the building. The DON was observed to demonstrate how as she turned, Resident #4 hit her left leg. The DON stated she almost fell, and she braced herself on the wheelchair of Resident #4 to catch herself. Resident #4 then screamed, "You hit me. You hit me." The DON stated she then knew she had to go. The DON stated Resident #4 threatened her. The DON restated that she almost fell. The DON explained if her hand touched Resident #4 it was because she was trying to catch herself from falling and defend herself from Resident #4. The DON stated her arms were "flaring" and then corrected herself saying her arms were "flying" to prevent Resident #4 from hitting her. The DON explained she worked too many years to have a resident say she hit them. The DON stated, "Do you think I would hit a resident? I know not to hit a resident. That would be my job. I would be fired if I hit a resident. Resident #4 is always up here talking loudly. I'm not going to ignore it." The DON stated she never said anything mean to Resident #4 and just told her to leave her alone. The DON stated she then went back into the building and sat down in her office because Resident #4 had tried to hit her with the wheelchair and then corrected herself and stated, "She hit me with the wheelchair." The DON confirmed she did "make contact with" Resident #4 to defend herself but did not hit her. The DON stated the Administrator and the police spoke with her that day.

Confidential Source #1 was interviewed on 2/13/2025 at 4:30 PM. Confidential Source #1 revealed the DON came to him/her directly after she returned to the building on 1/3/2025 and stated, "I know they will fire me. I hit her twice. I just hit her. I was gonna pull her out of that chair.

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She called me a [racial slur]." Confidential Source #1 stated the DON confessed to hitting Resident #4 twice. Confidential Source #1 stated that if he/she came forward, he/she was certain he/she would lose his/her job because he/she thought the facility was trying to cover up what happened.

Confidential Source #1 was interviewed again on 2/14/2025 at 11:56 AM. Confidential Source #1 reiterated the DON came back into the building from the side door directly after the incident outside on 1/3/2025. Confidential Source #1 confirmed the DON confessed she had hit Resident #4 because Resident #4 was calling the DON a racially charged name. Confidential Source #1 indicated he/she was told the DON had a right to defend herself. Confidential Source #1 revealed Resident #4 had aggression and had run into people with her wheelchair previously on several occasions, even having her wheelchair taken away from her by the facility previously.

Confidential Source #2 was interviewed on 2/13/2025 at 5:20 PM and provided the following description of what was witnessed on 1/3/2025. Confidential Source #2 was outside in a side trailer working with the door open. Confidential Source #2 heard a commotion with people shouting and cursing in the smoking area. Confidential Source #2 heard a hit and turned around to see the DON shouting at Resident #4 saying "Come on, Come on" right up in Resident #4's face. Resident #4 was screaming, "She hit me. She hit me." Confidential Source #2 stated, "[DON] just lost it on [Resident #4]." NA #1 was standing there telling the DON to just "Stop. Stop." The DON then went into the side door of the building. Confidential Source #2 stated the DON was suspended but returned to the facility in

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about 4 or 5 days. Confidential Source #2 confirmed he/she did not witness the DON hit Resident #4. Confidential Source #2 was told the DON had the right to protect herself, but it would set a bad precedent if it was known the DON hit Resident #4. Confidential Source #2 said there should be a video of the incident taken by the facility camera. Confidential Source #2 did not want his/her identity known out of fear of retaliation.

Confidential Source #3 was interviewed on 2/14/2025 at 1:45 PM and again at 4:09 PM. The following information was provided. Confidential Source #3 witnessed Resident #4 using her power wheelchair to run into Resident #3's wheelchair on the morning of 1/3/2025. Confidential Source #3 indicated the altercation between Resident #3 and Resident #4 was reported to the Administrator and the Social Worker immediately after it happened. Later in the day, on 1/3/2025, Confidential Source #3 went to the nursing office in the back of the building for a risk management meeting that was to start at noon. As Confidential Source #3 entered the door, the DON confessed, "I hit [Resident #4] two times." Confidential Source #3 immediately told the DON she must go to the Administrator to inform him what happened. Confidential Source #3 then walked with the DON directly to the Administrator. Confidential Source #3 then walked back to attend the risk management meeting in the nursing office and did not discuss what he/she heard with anyone else. Confidential Source #3 did not want the interview information used knowing he/she would be fired for revealing information. Confidential Source #3 did not know if anyone else heard the statement made by the DON in the office

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doorway.

The Unit Manager (Nurse #4) was interviewed on 2/14/2025 at 3:15 PM and she provided the following information. Nurse #4 stated she was at the nursing station in the back hall of the building after the risk management meeting on 1/3/2025 when she saw the DON coming down the hall and she was distressed and very emotional. The DON told Nurse #4 she was going home. Nurse #4 stated she pulled the DON into the office next to the nursing station to calm her down. Nurse #4 explained the DON was shaken up and shocked because Resident #4 had run her wheelchair into her.

NA #1 was reinterviewed on 2/14/2025 at 3:38 PM. NA #1 explained with the following information and additional details. Resident #4 was in the hallway swearing and cussing at Resident #3. The DON decided the residents should be taken out to smoke. The DON and NA #1 took Resident #3, Resident #4, and Resident #10 one at a time out the door to smoke. Outside Resident #4 tried to run the DON over with her wheelchair. The DON tried to run away. The DON was hit in the foot with the wheelchair of Resident #4. NA #1 explained it happened so fast he was not able to verify if the DON was swinging her arms. NA #1 was adamant that the DON never touched Resident #4 nor made contact with Resident #4 other than being hit by the wheelchair of Resident #4. Resident #4 was cussing at the DON but no direct contact was made. NA #1 reiterated it happened too fast for him to recall any more information.

Documentation on a police report dated 1/3/2025 at 12:04 PM revealed the incident involved a

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simple assault with a "hit with fist." The case was deemed closed, "by other means." The narrative on the police report was redacted. There were no witnesses listed. The victim was listed as Resident #4 and "others involved" were listed as the DON. Offender number one was listed as the DON and offender number two was Resident #4. Both the DON and Resident #4 were listed as suspects. Documentation in the police report revealed there were no injuries.

An interview was conducted with the Administrator on 2/14/2025 at 10:45 AM. The Administrator stated he completed his five-day investigation and determined Resident #4 ran her wheelchair into the DON causing her to lose her balance. The Administrator revealed the facility investigation concluded the abuse of Resident #4 was unsubstantiated. The Administrator revealed the full narrative of what happened, and the investigation results were submitted to the state. He stated that, as a company directive, there were no cameras in the building and no camera footage.

An interview was conducted with the Administrator and a Nurse Consultant on 2/18/2025 at 3:22 PM. The Nurse Consultant and the Administrator confirmed that the DON and NA #1 were interviewed as a part of the investigation. The Administrator stated there was nobody else to interview because nobody else was outside at the time of the altercation on 1/3/2025 to interview except for the three residents. The Administrator stated Resident #3 told him Resident #4 hit the DON with the wheelchair and Resident #10 did not see anything. The Administrator added that Resident #10 was not an interviewable resident. The Administrator

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F 600	Continued From page 21 stated on 1/3/2025 he heard hollering, so he walked outside toward the smoking area. The Administrator confirmed while outside he encountered NA #1 and Resident #4. Resident #4 told the Administrator that the DON hit her. The Administrator stated the police arrived 15 to 20 minutes later. The Administrator revealed he went to the DON's office and that was where he found her. The Administrator stated he did not see the picture of the bruise on the face of Resident #4. The Administrator confirmed all the investigation information was provided.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of	F 607		3/13/25

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F 607	Continued From page 22 employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to implement policies and procedures that promote a culture of safety and open communication in the workplace and prohibit potential retaliation for staff who report abuse allegations. Confidential Source #1, Confidential Source #2, and Confidential Source #3 all stated they did not come forward with information related to an abuse allegation due to a fear of retaliation. This was for 1 (Resident #4) of 3 residents reviewed for investigation of abuse allegations. Findings Included: Documentation on the facility's abuse, neglect, and exploitation policy, dated as last reviewed on 4/1/2024 revealed, "The Company will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: ....F. Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed." Documentation in an initial state agency report submitted to the state agency on 1/3/2025 at 3:20 PM revealed that Resident #4 stated she was struck by a nurse, who was suspended. The nurse in the initial investigation report was	F 607	Resident #4 continues to reside in the facility and remains in stable condition. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 3/5/2025 the Social Service (SS) and Staff Development Coordinator (SDC) completed a questionnaire of alert and oriented residents who score 12 and higher regarding reporting abuse and fear of retaliation to ensure residents understand that retaliation is not part of the culture of the facility when an occurrence is reported. Audit was completed on 3/6/2025. No concerns were identified. On 3/4/2025 the SDC initiated education with staff regarding abuse. Education included the definition of abuse, who to report abuse to, what constitutes abuse, and freedom from retaliation when reporting an occurrence to ensure staff understand that retaliation is not part of the culture of the facility when an occurrence is reported. Education was completed by 3/7/2025. After 3/7/2025 any staff who were not educated will be educated by the SDC prior to starting their	

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F 607	Continued From page 23 identified as the Director of Nursing (DON). Documentation on an investigation report submitted to the state agency on 1/10/2025 at 10:55 AM in part revealed in the summary of the facility investigation, "Resident (#4) followed her (DON) to the door and struck nurse (DON) on her leg with her (Resident #4's) electric scooter and started to swing her arms and legs at nurse (DON). Nurse (DON) put up her arms up to deflect the attempts by Resident (#4) to strike nurse. Nurse went back into center." Confidential Source #1 was interviewed on 2/13/2025 at 4:30 PM. Confidential Source #1 revealed the DON came to him/her directly after she returned to the building on 1/3/2025. Confidential Source #1 stated the DON confessed to hitting Resident #4 twice. Confidential Source #1 stated that if he/she came forward, he/she was certain he/she would lose his/her job because he/she thought the facility was trying to cover up what happened. Confidential Source #1 stated he/she was conflicted about providing the information because he/she would be protecting vulnerable residents, but he/she would lose his/her job. Confidential Source #2 was interviewed on 2/13/2025 at 5:20 PM and described what was witnessed on 1/3/2025. Confidential Source #2 was outside in a side trailer working with the door open and witnessed an altercation between Resident #4 and the DON. Confidential Source #2 said there should be a video of the incident taken by the facility camera confirming what he/she witnessed. Confidential Source #2 did not want his/her identity known out of fear of retaliation and agreed only to provide information	F 607	next scheduled shift. Newly hired staff will be educated by the SDC during orientation. An audit will be conducted with each allegation and/or grievance to ensure staff and/or residents report timely and without fear of retaliation. Audits will be conducted with each allegation and/or grievance weekly for 12 weeks. The NHA will forward the results of the audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will review the allegation/grievance audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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F 607	Continued From page 24 if his/her identity would not be known to the facility's administration. Confidential Source #3 was interviewed on 2/14/2025 at 1:45 PM and again at 4:09 PM. Confidential Source #3 described a confession overheard from the DON admitting to hitting Resident #4 on 1/3/2025. Confidential Source #3 did not want the interview information used knowing he/she would be fired for revealing information. Confidential Source #3 was certain facility administration would find a reason to fire him/her if it were known he/she came forward to support the claim of Resident #4 with what he/she heard from the DON. An interview was conducted with the Administrator and Nurse Consultant on 2/18/2025 at 3:22 PM. The Administrator was adamant the only people in the smoking area on 1/3/2025 who witnessed the altercation between Resident #4 and the DON were the three residents, Nurse Aide (NA) #1, and the DON. The Administrator stated he completed the investigation, and the Nurse Consultant stated she interviewed the DON and NA #1. The Administrator revealed that every building has staff who are afraid to talk despite being told they do not have to fear for their jobs if they come forward, but he did not know how to make the staff believe it. The Nurse Consultant confirmed the facility would not fire someone who came forward with information. The Administrator and the Nurse Consultant indicated they did not know how to prove or disprove an allegation of abuse if the confidential sources were not identified.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		3/13/25

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F 610	Continued From page 25 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to complete a thorough investigation following an abuse allegation by not assessing the alleged victim for injury for one (Resident #4) of three resident abuse investigations reviewed. Findings included: Documentation on the facility's abuse, neglect, and exploitation policy, dated as last reviewed on 4/1/2024, revealed under the heading of protection of the resident "examining the alleged victim for any sign of injury, including a physical examination or psychological assessment if needed." Documentation in an initial state agency report submitted to the state agency on 1/3/2025 at 3:20 PM revealed that Resident #4 stated she was	F 610	Resident #4 continues to reside in the facility and remains in stable condition. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 3/7/2025 the Regional Director of Clinical Services (RDCS) reviewed occurrence investigations for the past two (2) months to ensure the investigation of alleged occurrence has a thorough investigation completed with the needed components of the investigation gathered. On 3/7/2025 the Regional Director of Clinical Services (RDCS) completed education with the Assistant Director of Nursing (ADON), Nursing Home	

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F 610	Continued From page 26 struck by a nurse, who was suspended. The nurse in the initial investigation report was identified as the Director of Nursing (DON). Documentation on an investigation report submitted to the state agency on 1/10/2025 at 10:55 AM in part revealed in the summary of the facility investigation, "Resident (#4) followed her (DON) to the door and struck nurse (DON) on her leg with her (Resident #4's) electric scooter and started to swing her arms and legs at nurse (DON). Nurse (DON) put up her arms up to deflect the attempts by Resident (#4) to strike nurse. Nurse went back into center." There were no resident skin assessments and no skin assessment of Resident #4 directly after the altercation on 1/3/2025 in the facility file. Resident #4 was interviewed on 2/13/2025 at 11:05 AM and she confirmed that neither a skin assessment nor an assessment of her injuries was completed after the incident on 1/3/2025. A photograph, dated 1/3/2025, was observed on the telephone of Resident #4 depicting a bruise on the left side of her face near her chin. Resident #4 explained that she had shown the picture to the Administrator and the Social Worker. There was no documentation or statements from the Administrator or the Social Worker in the facility file regarding a photo taken by Resident #4 depicting a bruise on the left side of her face near her chin. An interview was conducted with the Administrator on 2/14/2025 at 10:45 AM. The Administrator stated he completed his five-day investigation and determined Resident #4 ran her	F 610	Administrator (NHA), Unit Manager (UM), and Social Service (SS) regarding investigating alleged occurrences and what their role is during the investigation process. As well as providing the RDCS with a copy/scan of the completed investigation. Newly hired DON, NHA, SDC, UM, and/or SS will be educated by the RDCS during orientation. The RDCS will review any alleged occurrences weekly for 12 weeks to ensure a thorough investigation has been completed and that components of the investigation are maintained by the NHA and RDCS. The NHA will forward the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee for three months. The QAPI Committee will review the audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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F 610	Continued From page 27 wheelchair into the DON causing her to lose her balance. The Administrator revealed the facility investigation concluded the abuse of Resident #4 was unsubstantiated. The Administrator revealed the full narrative of what happened, and the investigation results were submitted to the state agency. An interview was conducted with the Administrator and a Nurse Consultant on 2/18/2025 at 3:22 PM. The Administrator confirmed all the investigation information was provided. The Administrator and the Nurse Consultant would not confirm or deny a skin assessment of Resident #4 was completed on 1/3/2025. The Administrator stated he did not see the picture of the bruise Resident #4's face.	F 610		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide an environment free of hazards by putting a heater in the hallway and space heaters in 5 (Rooms 102, 103, 104, 105, and 106) of 6 resident rooms reviewed for tripping hazards. Findings included: Observations were made on an initial tour of the	F 689	Residents #16, 15, 18 continue to reside in the facility and remain in stable condition. Resident #9 no longer resides in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 2/18/2025 the	3/13/25

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F 689	Continued From page 28 facility on 2/13/2025 beginning at 9:04 AM. The facility had an industrial-sized heater in the hallway outside the Admissions Office with a large cord running from the back of the unit. The cord to the industrial sized heater was not taped down but curved out the back of the unit into the admission's office. Residents in wheelchairs were observed to navigate in the hallway around the heater in the hallway. Resident # 9 was observed in his wheelchair attempting to navigate around the industrial heater in the hallway. Resident #9 stated, "This is ridiculous with this thing in the hallway." Resident rooms 102, 103, 104, 105, and 106 were observed to have space heaters in the rooms. The cords to the space heaters in the resident rooms were not taped down to the floor. In rooms 106 and 102 space heaters were located near the doorway to the room in the pathway to the bathroom, requiring residents in those rooms to roll their wheelchairs around the space heater to get to the bathroom. Documentation on a quarterly Minimum Data Set assessment dated 1/14/2025 revealed Resident #16 was coded as cognitively intact. An interview and observation were conducted with Resident #16 (Room 106B) and Resident #15 (Room 106A) on 2/13/2025 at 12:56 PM. Resident #16 was in a wheelchair and Resident #15 was ambulatory with a four-wheel rollator rolling walker. Resident #15 was observed to navigate around the space heater near the entrance of the room to exit the room. Resident #16 stated the facility has been without heat for the rooms in the front of the building for three weeks. Resident #16 explained that a big heater was placed in the hallway and that there were space heaters in each resident's room.	F 689	Director of Plant Operations spoke with Life Safety Engineering Supervisor regarding industrial heater located in the hallway of resident rooms 102 through 106. The Director of Plant Operations and the Life Safety Engineering Supervisor discussed locations for the industrial heater. It was agreed upon to move the industrial heater into the empty former admissions office. In this room the heater could face toward the opposite hallway wall and continue to warm rooms 102 through 106. The space heaters that were in resident rooms were removed. Heat exchange part is due to be delivered on 3/22/2025. On 2/18/2025 the Director of Plant Operations completed education with the Nursing Home Administrator (NHA) and the Maintenance Director regarding inspecting components of electrical equipment brought into the facility and ensure the electrical equipment is not placed in an area that could potentially create a hazard to staff and/or residents. The NHA or Maintenance Director will conduct an audit of five (5) rooms per week for 12 weeks to ensure resident rooms or common areas that have electrical equipment are tagged with inspection date, are in working order, and are not creating a hazard for staff and/residents. The NHA will forward the results of the audit to the Quality Assurance Performance Improvement (QAPI)	

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F 689	Continued From page 29 An interview was conducted with Resident #18 in Room 102A on 2/14/2025 at 12:50 PM. Resident #18 stated his space heater at the entrance to the room did not work because it tripped the circuit breaker when it was turned on. Resident #18 stated he did have to navigate around the space heater, but it did not bother him. An observation was made on 2/14/2025 at 7:20 AM with the Maintenance Director in Resident 16's room. The room contained two space heaters with cords spread out on the floor. An additional observation was made on 2/14/2025 at 12:50 PM in Room 102. The room contained a space heater near the entrance and another space heater sitting directly next to the resident near the window of the room. The Administrator was interviewed on 2/13/2025 at 1:35 PM. The Administrator revealed the heating system went out and a part needed to be manufactured due to the age of the system. The Administrator added that an industrial heater was immediately put in the hallway and space heaters in the resident rooms to keep them warm. An interview was conducted on 2/17/2025 at 1:32 PM with the Life Safety Engineering Supervisor for the state agency. The Life Safety Engineering Supervisor revealed it was a life safety code violation to have electric heaters and/or space heaters in the hallways, resident rooms, or resident care areas due to fire risk. The Director of Plant Operations was interviewed on 2/18/2025 at 8:38 AM and the following information was provided. On 1/19/2025 the	F 689	Committee monthly for three (3) months. The QAPI Committee will review the audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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F 689	Continued From page 30 facility reported having issues with the heat exchanger on the outside heating and air conditioning unit. On 1/20/2025 contractors unsuccessfully attempted to fix the heat exchanger. A new part will be manufactured at the factory within 30 days. On 1/21/2025 the six rooms that contained residents received space heaters and a large electric heater was put in the hallway. The space heaters purchased were unapproved for safety in the facility. The facility has had someone on fire watch all night since the space heaters were purchased for the hallway and resident rooms.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		3/13/25

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F 755	Continued From page 31 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and pharmacy interviews, the facility failed to have an effective system in place for putting new admission orders into the electronic record to ensure pharmacy delivery, resulting in four missed doses of antibiotics for one (Resident #7) of two residents reviewed for pharmacy services. Findings included: Resident #7 was admitted to the facility on 1/21/2025 from the hospital and discharged back to the hospital on 1/28/2025. Resident #7 had a diagnosis of osteomyelitis. Documentation on a discharge summary from the hospital dated 1/21/2024 revealed Resident #7 was started on intravenous Vancomycin and Cefepime for osteomyelitis of the left elbow planned for a six-week (1/7/25-2/18/25) course via peripherally inserted central catheter (PICC line). (A PICC line is a thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein above the heart.) Vancomycin and Cefepime are antibiotics used to treat infection. The current discharge medication list for Resident #7 included: 1 gram (g)/250 milliliters (ml) IVPB (intravenous piggyback) of Vancomycin in 0.9% sodium chloride to be injected into the vein daily	F 755	Resident #7 no longer residents in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 3/5/2025 the Assistant Director of Nursing (ADON), Unit Manager (UM) completed an audit of current residents who are ordered intravenous (IV) antibiotic treatments to ensure antibiotic orders were written correctly, arrived from pharmacy, and first dose given as ordered taking into account new admissions who would have received a dose at the hospital. No further concerns identified. On 3/5/2025 the Staff Development Coordinator (SDC) initiated education with licensed nursing staff regarding correctly writing a medication order under the heading of Pharmacy, even if it is a house-stock medication, checking the facility's back-up system for the ordered medication, notifying the physician for further orders, notifying the pharmacy with alternative order and/or alternative pharmacy, and completing a progress	

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F 755	Continued From page 32 for 31 days and 2 g/110 ml IVPB Cefepime in 0.9% sodium chloride to be injected into the vein every 12 hours for 31 days. Documentation in the nursing progress notes written by Nurse #7 for Resident #7 revealed he was admitted to the facility on 1/21/2025 at 3:02 PM. Documentation on a physician order dated 1/21/2025 written by Nurse #4 revealed an order was entered into the electronic medical record of Resident #7 for 1 g/250 ml Vancomycin in 0.9% sodium chloride to be injected into the vein. The order type was selected as "Other Orders (MAR)." There was no evidence that a physician's order for Cefepime was entered into the electronic medical record for Resident #7 on 1/21/2025. Documentation on the Medication Administration Record (MAR) revealed Resident #7 did not receive an IV Cefepime dose on 1/21/2025 at 5:00 PM or 1/22/2025 at 5:00 AM. Documentation on the MAR revealed Resident #7 did not receive an IV Vancomycin dose on 1/22/2025 at 6:30 AM. Documentation in the physician orders revealed an order was initiated on 1/21/2025 at 3:00 PM for 5 ml Heparin 10 units/ml flush solution and 10 ml normal saline flush solution to be used intravenously every shift to maintain the PICC line. The order type was selected as, "AHR Medication Orders." AHR stands for admission, transfers, and discharge report.	F 755	note with interventions taken. Education was completed by 3/7/2025. After 3/7/2025 licensed nurses not educated will be educated by the SDC prior to beginning their next. Newly hired licensed nurses will be educated by the SDC during orientation. The Assistant Director of Nursing (ADON) will complete an audit for 12 weeks with each IV antibiotic order to ensure the order is entered into the electronic medication administration record (eMAR) correctly, back-up system is utilized until medication is obtained from pharmacy, notifying physician for further orders if the medication is not available in the back-up system, notifying pharmacy with alternative order and/or alternative pharmacy, and a progress note is completed with interventions taken. ADON will forward the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review IV antibiotic audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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CAMELLIA GARDENS CENTER FOR NURSING AND REHAB	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(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
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Documentation on the MAR revealed Resident #7 was administered the Heparin flush on 1/21/2025 on the evening shift (3:00 PM to 11:00 PM) and the night shift (11:00 PM to 7:00 AM shift) by Nurse #5.

Nurse #5 was interviewed on 2/19/2025 at 3:40 PM. Nurse #5 confirmed she was assigned to care for Resident #7 for the evening shift on 1/21/2025 and the night shift ending at 7:00 AM on 1/22/2025. Nurse #5 confirmed she did administer the Heparin and normal saline flush for the PICC line for Resident #5 as ordered on the 1/21/2025 evening shift and the night shift. Nurse #5 stated she did not have the antibiotics (Vancomycin or Cefepime) from the pharmacy to give Resident #5 on 1/21/2025 or 1/22/2025.

Documentation in the nursing progress notes for Resident #7 dated 1/22/2025 at 8:28 AM written by Nurse #7 revealed, "Notified NP (Nurse Practitioner) from [Medical Group name] that both antibiotic prescriptions [were discontinued] because it initially entered under other instead of pharmacy, therefore pharmacy did not receive [prescription]. Called pharmacy, writer advised to re-enter medications under pharmacy. Unable to enter medications, attempted to provide verbal order. Sent to voice mail. NP aware. Advised that MD (Medical Doctor) will be in office this shift and see if she can enter order and verify that verbal order was taken."

Nurse #7 was interviewed on 1/18/2025 at 12:33 PM. Nurse #7 indicated when Resident #7 was admitted on 1/21/2025 and Nurse #4 assisted with the admission orders. Nurse #7 revealed on the morning of 1/22/2025 she realized the antibiotics required for Resident #7 did not come

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in from the pharmacy. Nurse #7 stated the orders for the antibiotics were put in as the order type of "other" and those orders had to be discontinued. Nurse #7 further explained that if the order type selected had been "AHR Medication Orders," the medication orders would have been sent directly from the electronic health record to the pharmacy. Nurse #7 explained she was initially unable to change the antibiotic orders, so she was on the phone with the IV (intravenous) department at the pharmacy for 20 minutes as they walked her through how to enter the orders for the IV antibiotics into the electronic medical record so the pharmacy would receive them. Nurse #7 indicated the pharmacy delivered medications to the facility between 12:00 AM and 3:00 AM so, Resident #7 was not able to receive the antibiotics until 1/23/2025. Nurse #7 did not know and could not remember if the IV antibiotics ordered for Resident #7 were in the automated medication dispensing system. Nurse #7 explained she was orienting a new nurse on 1/22/2025 on the 7:00 AM to 3:00 PM shift and she did not have time to look in the automated dispensing system or the backup pharmacy.

Nurse #4 was interviewed on 2/18/2025 at 9:17 AM. Nurse #4 confirmed she put the initial orders for Resident #7 into the electronic medical record for transmission to the pharmacy. Nurse #4 stated that as the Unit Manager she helped the nursing staff with new admissions. Nurse #4 stated it looked like the orders were changed in the electronic medical record and the facility was awaiting the arrival of the antibiotics from the pharmacy. Nurse #4 explained that if an order type was entered as "other" then the order does not go to the pharmacy to be filled, and the nurses do not have to check off the order as

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being completed on the MAR. Nurse #4 stated the facility not receiving the antibiotics for Resident #7 was either a pharmacy issue or the physician changed the orders. Nurse #4 did not have an explanation why she entered the order in as "other" for the antibiotic Vancomycin. Nurse #4 also did not know why the order for Cefepime was not entered on 1/21/2025 for Resident #7, but she would "look into it."

Documentation on the Medication Administration Record (MAR) revealed Resident #7 did not receive an IV Cefepime dose on 1/22/2025 at 5:00 PM. The Medication Administration note dated 1/22/2025 at 9:02 PM by Nurse #6 stated, "Rescheduled awaiting pharmacy."

Nurse #6 was interviewed on 2/19/2025 at 3:53 PM. Nurse #6 confirmed he was assigned to care for Resident #7 for the IV administration of Cefepime on 1/22/2025 at 5:00 PM. Nurse #6 stated that if the Cefepime was not documented as administered then he did not have the IV antibiotic Cefepime to administer to Resident #7.

Pharmacist #1 from the facility pharmacy was interviewed on 2/18/2025 at 1:04 PM. Pharmacist #1 stated the pharmacy received Resident #7's prescriptions for Vancomycin and Cefepime on 1/22/2025 with a start date of 1/23/2025. Pharmacist #1 stated the IV antibiotics Vancomycin and Cefepime for Resident #7 were delivered to the facility at 1:11 AM on 1/23/2025. Pharmacist #1 stated the only orders received on 1/21/2025 for intravenous administration for Resident #7 were for the Heparin and normal saline flush.

The Director of Nursing (DON) was interviewed

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F 755	Continued From page 36 on 1/18/2025 at 2:17 PM. The DON stated she knew that the facility would not have the Vancomycin and Cefepime to administer to Resident #7, so she called the hospital requesting they send the IV Vancomycin and Cefepime with Resident #7. The DON revealed that Resident #7 was already en route when she called. The DON indicated that if the antibiotics were not available for Resident #7 upon admission, then the facility would have added additional doses to the end of the six-week antibiotic administration timeline so he would have received all the ordered doses. The DON did not think the antibiotics Vancomycin and Cefepime were actually in the automated medication dispensing system to be administered to Resident #7 upon his admission. The Medical Doctor (MD #1) for Resident #7 was interviewed on 2/19/2025 at 1:35 PM. MD #1 stated she did not think it was a realistic expectation for the facility to have been able to provide the scheduled Cefepime dose on 1/21/2025 scheduled at 5:00 PM to Resident #7 because he had just been admitted to the facility. MD #1 conceded Resident #7 should have gotten the antibiotics he needed when he was admitted.	F 755		
F 759 SS=E	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, staff interviews, and record review, the facility failed to have a	F 759	Resident #11 continues to reside in the facility and remains in stable condition.	3/13/25

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F 759	Continued From page 37 medication error rate of less than 5% as evidenced by 4 medication errors out of 25 opportunities resulting in a medication error rate of 16% for 2 (Residents #11 and #12) of 5 residents observed during medication administration observation. Findings included: 1-a. On 2/14/2025 at 7:51 AM, Medication Aide (Med Aide) #1 was observed and interviewed as she prepared and administered four medications to Resident #11. Med Aide #1 stated during the preparation of medications for Resident #11 that she did not have the eye drops in the medication cart she needed for Resident #11. Med Aide #1 did not administer eye drops to Resident #11 during the medication pass observation. A review of Resident #11's medication orders revealed the resident had a current order for Carboxymethylcellulose sodium PF (preservative-free) ophthalmic solution to be instilled as one drop in both eyes one time a day for the treatment of dry eyes (ordered on 1/28/2025). Med Aide #1 was interviewed at 1:35 PM. Med Aide #1 confirmed she did not administer the eye drops Carboxymethylcellulose sodium PF ophthalmic solution to Resident #11 and the eye drops were on order. 1-b. On 2/14/2025 at 8:39 AM, Nurse # 3 was observed as she prepared and administered eight medications to Resident #12. The medications administered included one- 325 milligram (mg) tablet of Sodium Bicarbonate administered by mouth, one-667 mg capsule of Calcium Acetate administered by mouth, and one-25 mg capsule of Hydroxyzine Pamoate administered by mouth.	F 759	The Nurse Practitioner was notified of Resident #11 eye drop administration omission. Order received to administer eye drops when received. Eye drops were received on 2/14/2025. Resident #12 no longer resides in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 2/24/2025 the Director of Nursing (DON) and Unit Manager (UM) completed an audit of facility's medication carts to ensure the medication in the medication cart matched the order. Any identified concerns were corrected by the UM and/or pharmacist. On 3/4/2025 the Staff Development Coordinator (SDC) educated licensed nurses and certified medication aides (CMA) regarding medication orders matching medication form. Education included comparing order and form to ensure they match, notification of physician and pharmacy of incorrect, and completing a progress note of interventions taken. Education was completed by 3/7/2025. After 3/7/2025 licensed nurses or CMAs who have not been educated will be educated by the SDC prior to beginning their next scheduled shift. Newly hired licensed nurses and/or CMS will be educated by the SDC during orientation. The UM/SDC will complete medication order/form audit on one (1) medication cart two (2) times a week for four (4)	

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F 759	Continued From page 38 A review of Resident #12's medication orders revealed the resident had a current order for one-650 mg tablet of Sodium Bicarbonate to be administered three times a day by mouth for indigestion (ordered on 1/29/2025). A review of Resident #12's medication orders revealed the resident had a current order for two-667 mg capsules of Calcium Acetate to be administered three times a day by mouth after meals for acute kidney injury (ordered on 2/8/2025). A review of Resident #12's medication orders revealed the resident had a current order for one-50 mg capsule of Hydroxyzine Pamoate to be administered three times a day by mouth for anxiety. An interview was conducted with Nurse #3 on 2/14/2025 at 2:05 PM. During the interview the discrepancies in the medication Sodium Bicarbonate, Calcium Acetate, and Hydroxyzine Pamoate amounts prepared and administered versus the current physician orders were discussed. Nurse #3 reviewed the order for the Sodium Bicarbonate for Resident #12 and stated that the pill bottle contained 350 mg tablets while Resident #12 was ordered to have 650 mg of Sodium Bicarbonate. Nurse #3 stated she should have given Resident #12 two-350 mg tablets of Sodium Bicarbonate to fulfill the order. (Two tablets of 350 mg Sodium Bicarbonate would have been equivalent to 700 mg of the medication.) Nurse #3 reviewed the order for the Calcium Acetate for Resident #12 and acknowledged that she had only given one-667 mg capsule of Calcium Acetate at 8:00 AM	F 759	weeks then one (1) time a week for eight (8) weeks, alternating carts. The audit is to ensure the medication in the medication cart match the order and if it does not match, notification is made to the physician and/or pharmacy. ADON will forward the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee for three (3) months. The QAPI Committee will review the medication audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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F 759	Continued From page 39 medication administration time. She stated she knew that she had given Resident #12 two-667 mg capsules of Calcium Acetate at noon on the same day and revealed she should have looked closer at the order and administered two capsules at 8:00 AM. Nurse #3 reviewed the physician's order for Hydroxyzine Pamoate for Resident #12 and looked at the blister packet of medication in the medication cart. (A blister pack is a form of tamper evident packaging where an individual pushes individually sealed tablets or capsules through the foil to take the medication.) Nurse #3 noted that the blister packet of Hydroxyzine Pamoate for Resident #12 was labeled as containing one-25 mg capsule of the medication in each preformed dome. Nurse #3 stated that she should have caught the discrepancy in the medication order and the labeled blister packet of Hydroxyzine Pamoate and administered two capsules to Resident #12 to fulfill the medication order. The Director of Nursing (DON) was interviewed on 1/18/2025 at 2:17 PM. The DON stated that the nurses were supposed to administer medications to the residents as ordered on the Medication Administration Record and that she would have to make sure the medications available on the medication carts matched the orders.	F 759		
F 760 SS=D	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:	F 760		3/13/25

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F 760	Continued From page 40 Based on record review, and staff, Pharmacist and Medical Doctor interviews, the facility failed to administer four doses of antibiotics and one dose of insulin upon admission for one (Resident #7) of two residents reviewed for significant medication errors. Findings included: Resident #7 was admitted to the facility on 1/21/2025 from the hospital. Resident #7 had diagnoses of diabetes and osteomyelitis. Documentation on a discharge summary from the hospital dated 1/21/2024 revealed Resident #7 was started on intravenous Vancomycin and Cefepime for osteomyelitis of the left elbow planned for a six-week (1/7/25-2/18/25) course via peripherally inserted central catheter (PICC line). (A PICC line is a thin, flexible tube inserted into a vein in the upper arm and threaded into a large vein above the heart.) Vancomycin and Cefepime are antibiotics used to treat infection. The current discharge medication list for Resident #7 included: 1 gram (g)/250 milliliters (ml) IVPB (intravenous piggyback) of Vancomycin in 0.9% sodium chloride to be injected into the vein daily for 31 days; 2 g/110 ml IVPB Cefepime in 0.9% sodium chloride to be injected into the vein every 12 hours for 31 days; and; and 10 units of Glargine insulin injected subcutaneously once daily. Insulin is used to treat diabetes mellitus. Documentation in the nursing progress notes written by Nurse #7 for Resident #7 revealed he was admitted to the facility on 1/21/2025 at 3:02 PM. a. Documentation on a physician order dated 1/21/2025 written by Nurse #4 revealed an order was entered into the electronic medical record of	F 760	Resident #7 no longer residents in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 2/24/2025 the Director of Nursing (DON) and Unit Manager (UM) completed an audit of the facility medication carts to ensure residents have a supply of their ordered medications. No concerns identified. On 3/4/2025 the Staff Development Coordinator (SDC) initiated education with licensed nursing staff regarding checking the facility's back-up system for the ordered medication, notifying the physician for further orders, notifying the pharmacy with alternative order and/or alternative pharmacy, and completing a progress note with interventions taken. Education was completed by 3/7/2025. After 3/7/2025 licensed nurses not educated will be educated by the SDC prior to beginning their next. Newly hired licensed nurses will be educated by SDC during orientation. The Assistant Director of Nursing (ADON) will complete an audit of new admissions two (2) times a week for four (4) weeks then one (1) time a week for 2 months to ensure new admission/readmission ordered medications have been obtained from back-up system and if not in back-up system, the physician and pharmacy were notified for further orders, and a progress note is completed with interventions taken.	

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F 760	Continued From page 41 Resident #7 for 1 g/250 ml Vancomycin in 0.9% sodium chloride to be injected into the vein. There was no evidence that a physician's order for Cefepime was entered into the electronic medical record for Resident #7 on 1/21/2025. Nurse #4 was interviewed on 2/18/2025 at 9:17 AM. Nurse #4 confirmed she put the initial orders for Resident #7 into the electronic medical record for transmission to the pharmacy. Nurse #4 stated that as the Unit Manager she helped the nursing staff with new admissions. Nurse #4 did not have an explanation why she entered the order in as "other" for the antibiotic Vancomycin. Nurse #4 also did not know why the order for Cefepime was not entered on 1/21/2025 for Resident #7, but she would "look into it." Nurse #4 stated she did not know why Resident #7 missed the initial doses of his intravenous antibiotics. Nurse #4 did not know if the facility had intravenous antibiotics in the automated medication dispensing system. Documentation on the Medication Administration Record (MAR) revealed Resident #7 did not receive an IV Cefepime dose on 1/21/2025 at 5:00 PM or 1/22/2025 at 5:00 AM. Documentation on the MAR revealed Resident #7 did not receive an IV Vancomycin dose on 1/22/2025 at 6:30 AM. Documentation in the physician orders revealed an order was initiated on 1/21/2025 at 3:00 PM for 5 ml Heparin 10 units/ml flush solution and 10 ml normal saline flush solution to be used intravenously every shift to maintain the PICC line.	F 760	ADON will forward the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review the admission/readmission ordered medication audit tool to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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Documentation on the MAR revealed Resident #7 was administered the Heparin flush on 1/21/2025 on the evening shift (3:00 PM to 11:00 PM) and the night shift (11:00 PM to 7:00 AM shift) by Nurse #5.

Nurse #5 was interviewed on 2/19/2025 at 3:40 PM. Nurse #5 confirmed she was assigned to care for Resident #7 for the evening shift on 1/21/2025 and the night shift ending at 7:00 AM on 1/22/2025. Nurse #5 confirmed she did administer the Heparin and normal saline flush for the PICC line for Resident #5 as ordered on the 1/21/2025 evening shift and the night shift. Nurse #5 stated she did not have the antibiotics from the pharmacy Vancomycin or Cefepime to give Resident #5 on 1/21/2025 or 1/22/2025. Nurse #5 stated she did not know if the antibiotics were in the automated medication dispensing system. Nurse #5 confirmed she did have access to the automated medication dispensing system. Nurse #5 explained she would not have been able to get the IV antibiotics out of the automated medication dispensing system if they were in there, because the facility did not have the required two Licensed Practical Nurses on her shift to open the automated medication dispensing system.

Nurse #7 was interviewed on 1/18/2025 at 12:33 PM. Nurse #7 revealed on the morning of 1/22/2025 she realized the antibiotics required for Resident #7 did not come in from the pharmacy. Nurse #7 explained she was initially unable to change the antibiotic orders, so she was on the phone with the IV (intravenous) department at the pharmacy for 20 minutes as they walked her through how to enter the orders for the IV

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antibiotics into the electronic medical record so the pharmacy would receive them. Nurse #7 indicated the pharmacy delivered medications to the facility between 12:00 AM and 3:00 AM so, Resident #7 was not able to receive the antibiotics until 1/23/2025. Nurse #7 did not know and could not remember if the IV antibiotics ordered for Resident #7 were in the automated medication dispensing system. Nurse #7 explained she was orienting a new nurse on 1/22/2025 on the 7:00 AM to 3:00 PM shift and she did not have time to look in the automated dispensing system or the backup pharmacy.

Documentation on the Medication Administration Record (MAR) revealed Resident #7 did not receive an IV Cefepime dose on 1/22/2025 at 5:00 PM. The Medication Administration note dated 1/22/2025 at 9:02 PM by Nurse #6 stated, "Rescheduled awaiting pharmacy."

Nurse #6 was interviewed on 2/19/2025 at 3:53 PM. Nurse #6 confirmed he was assigned to care for Resident #7 for the IV administration of Cefepime on 1/22/2025 at 5:00 PM. Nurse #6 stated that if the Cefepime was not documented as administered then he did not have the IV antibiotic Cefepime to administer to Resident #7. Nurse #6 revealed the facility did not have IV antibiotics in the automated medication dispensing system.

Pharmacist #1 from the facility pharmacy was interviewed on 2/18/2025 at 1:04 PM. Pharmacist #1 stated the pharmacy received Resident #7's prescriptions for Vancomycin and Cefepime on 1/22/2025 with a start date of 1/23/2025. Pharmacist #1 stated the IV antibiotics Vancomycin and Cefepime for Resident #7 were

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delivered to the facility at 1:11 AM on 1/23/2025. Pharmacist #1 stated the only orders received on 1/21/2025 for intravenous administration for Resident #7 were for the Heparin and normal saline flush. Pharmacist #1 revealed Resident #7 did not need to miss any doses of antibiotics because both the Vancomycin and Cefepime were in the automated medication dispensing system.

The Director of Nursing (DON) was interviewed on 1/18/2025 at 2:17 PM. The DON stated she knew that the facility would not have the Vancomycin and Cefepime to administer to Resident #7, so she called the hospital requesting they send the IV Vancomycin and Cefepime with Resident #7. The DON revealed that Resident #7 was already en route when she called. The DON revealed that she did not think the IV Vancomycin and IV Cefepime were in the automated medication dispensing system on 1/21/2025 when Resident #7 was admitted.

Pharmacist #1 was interviewed again on 1/18/2025 at 2:59 PM. Pharmacist #1 revealed that according to the pharmacy documentation, from 1/21/2025 through 1/22/2025, the facility had three vials of 1g of Vancomycin and three vials of 2 g of Cefepime in addition to full IV boxes with additional IV Vancomycin and IV Cefepime in the backup supply.

Documentation on an inventory snapshot of the automated medication dispensing system dated 1/21/2024 through 1/22/2024 revealed the facility had three vials of 2 g Cefepime solution and three vials of 1g Vancomycin solution listed.

The Medical Doctor (MD #1) for Resident #7 was

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interviewed on 2/19/2025 at 1:35 PM.MD #1 stated that Resident #7 shouldn't have missed the antibiotics and there were ways to mitigate this if the hospital had worked with the facility to provide the initial doses of the needed antibiotic. MD #1 explained Resident #7 would not have any long-term effects from missing the initial doses of Vancomycin and Cefepime when he was first admitted. MD #1 further explained his creatinine level was fine, and the antibiotics stayed in the system for a while. (Vancomycin may cause serious effects to kidneys for which creatinine levels are monitored.)

b. Documentation on a physician order dated 1/21/2025 written by Nurse #4 revealed an order was entered into the electronic medical record for Resident #7 for 10 units of Glargine solution 100 units/ml injected subcutaneously one time a day for diabetes. This order was supposed to start on 1/22/2025 at 9:00 AM but was discontinued on 1/21/2025 at 4:15 PM by Nurse #4.

There was no documentation on the Medication Administration Record (MAR) of 10 units of Glargine solution 100 units/ml administered to Resident #7 on 1/22/2025 at 9:00 AM. The documentation on the MAR revealed the order was discontinued on 1/21/2025 at 4:15 PM so, there was no space on the MAR requiring documentation of administration at 9:00 AM on 1/22/2025.

Nurse #4 was interviewed on 2/18/2025 at 9:17 AM. Nurse #4 stated she thought the insulin order for Resident #7 was changed on 1/21/2025 and did not arrive until the next day as an explanation for why the order for insulin was discontinued on 1/21/2024.

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F 760	Continued From page 46 Nurse #7 was interviewed on 2/18/2025 at 12:33 PM. Nurse #7 stated on 1/22/2025 she was orienting a new nurse on the medication cart from 7:00 AM to 3:00 PM. Nurse #7 stated she did not recall anything about insulin for Resident #7. An interview was conducted with Pharmacist #1 from the facility pharmacy on 2/18/2025 at 1:04 PM. Pharmacist #1 revealed that the insulin Glargine was available to the facility on 1/22/2025, in a backup fridge kit. Pharmacist #1 revealed that the pharmacy received the order for the insulin Glargine for Resident #7 on 1/21/2025 with the medication filled and delivered to the facility on 1/22/2025 at 3:17 AM. The Director of Nursing was interviewed on 1/18/2025 at 2:17 PM. The Director of Nursing did not know why Resident #7 did not receive the 10 units of Glargine insulin on 1/22/2025 at 9:00 AM or if there was communication with the physician. The Medical Doctor (MD #1) for Resident #7 was interviewed on 2/19/2025 at 1:35 PM. MD #1 stated a possible reason for not administering the Glargine insulin to Resident #7 was because of a therapeutic interchange. (A therapeutic interchange is when a doctor switches a patient's prescription to a different drug that has similar therapeutic effects.) MD #1 stated Resident #7 should have been able to get the medications he was ordered to receive.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		3/13/25

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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 §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 48 (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, the facility failed to follow infection control policies and procedures by 1) donning a gown for enhanced barrier precautions during wound care for one (Nurse #1) of two staff members observed for enhanced barrier precautions, 2) performing hand sanitization in between residents during a medication pass observation for one (Medication Aide #1) of two staff members observed for hand hygiene, and 3) using gloves when handling medication during a medication pass observation for one (Nurse #3) of three staff members observed for glove use during care. Findings included:	F 880	Residents # 11 and 13 continue to reside in the facility and remain in stable condition. Residents #9 and 12 no longer reside in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. On 2/24/2025 the Staff Development Coordinator (SDC) initiated education with staff, to include Nurse #1, regarding appropriate use of personal protective equipment (PPE) emphasizing the correct PPE to be worn for each type of	

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F 880	Continued From page 49 1. Documentation on the facility's undated infection prevention and control program policy revealed under the heading standard precautions, "All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE." An observation was conducted on 2/13/2025 beginning at 1:40 PM while Resident #9 received wound care. Resident #9 was observed to have a sign on his room door for contact precautions. The documentation on the sign stated, "Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces." Nurse #1 and Nurse Aide (NA) #1 were observed to enter the room of Resident #9 and not put on gowns. NA #1 moved the motorized wheelchair of Resident #9 and removed the protective boots on the lower legs and feet. Nurse #1 explained the location of the resident's wounds were on the plantar side of the left and right feet and that the right foot wound had tested positive for MRSA (Methicillin-resistant Staphylococcus aureus). (MRSA is contagious and can spread to others through skin-to-skin contact.) Nurse #1 was observed to provide wound care as ordered to both the left and right feet of Resident #9, including removing soiled bandages, application of treatments, and redressing of the wounds. Directly after the wound care observation on 2/13/2025 at 2:08 PM Nurse #1 was interviewed. Nurse #1 stated that the required PPE was not outside the door of Resident #9. Nurse #1 added that some facilities follow the procedure of putting on a gown before wound care and some do not.	F 880	precaution. Education was completed by 3/7/2025. After 3/7/2025 any staff that was not educated will be educated prior to starting their next scheduled shift. Any newly hired staff will be educated during orientation. On 2/24/2025 the SDC initiated education with licensed nurses and certified medication aides (CMA), to include CMA #1 and Nurse #3, regarding completing hand hygiene before and after administering each residents medication and to take care that medication does not touch the bare hand when removing medication from its container. Education was completed by 3/7/2025. After 3/7/2025 licensed nurses or CMAs not educated will be educated by the SDC prior to starting their next scheduled shift. Newly hired licensed nurses or CMAs will be educated by the SDC during orientation. The SDC/Unit Manager or designee will complete an audit of 5 PPE use observations two (2) times a week for four (4) weeks then one (1) time a week for two (2) months. The audit will be completed to ensure staff entering a room with precautions are donning the appropriate PPE for the specific task being completed. The SDC/Unit Manager or designee will complete an audit of 5 nurses/CMAs two (2) times a week for four (4) weeks then one (1) time a week for two (2) months to ensure 1) hand hygiene is performed before and after each resident and 2) that	

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F 880	Continued From page 50 Nurse #1 revealed she had already put on a gown for wound care three times that day. Nurse #1 added that she did not get close to Resident #9 while performing wound care. The Director of Nursing was interviewed on 2/13/2025 at 2:10 PM. The Director of Nursing stated that Nurse #1 would need to be reeducated because for a resident on contact precautions, a gown must be worn for the provision of wound care. 2. Documentation on the facility's undated infection prevention and control program policy revealed under the heading standard precautions, "Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures." Documentation under the facility's undated Medication Administration policy revealed under policy explanation and compliance guidelines in part, "4. Wash hands prior to administering medication per facility protocol and product"; "16. Observe resident consumption of medication"; and "17. Wash hands using facility protocol and product." On 2/14/2025 at 7:51 AM, Medication Aide (Med Aide) #1 was observed as she prepared and administered medications to Resident #11. The room door of Resident #11 was observed to have a contact precaution sign on the door. The contact precaution sign indicated hand hygiene was required before entering the room and after leaving the room. Medication Aide #1 did not perform hand hygiene before entering Resident #11's room and did not perform hand hygiene after administering medications to Resident #11.	F 880	care is taken during medication administration that medications do not touch the bare hand. The Assistant Director of Nursing will forward the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review the infection control audit tools to determine trends and/or issues that may need further interventions put in place and/or determine the need for additional monitoring.	

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On 2/14/2025 at 8:01 AM, Med Aide #1 was observed as she prepared and administered medications to Resident #13. While in the room waiting for Resident #13 to consume her medications, Med Aide #1 assisted the resident, cutting up the food she was eating. Med Aide #1 did not perform hand hygiene before preparing the medications for Resident #13 nor when she returned to the medication cart after administration.

On 2/14/2025 at 8:17 AM, Med Aide #1 was observed as she prepared and administered medications to Resident #14. Med Aide #1 did not perform hand hygiene before preparing the medications for Resident #14 nor when she returned to the medication cart after administration.

Med Aide #1 was interviewed on 2/14/2025 at 8:20 AM. Med Aide #1 stated she usually did hand hygiene before preparing medications and after administering medications to residents, but she was just nervous. Med Aide #1 stated she especially performed hand hygiene when residents were on contact precautions. At that point, Med Aide #1 was observed to perform hand hygiene.

An interview was conducted with the Director of Nursing on 2/18/2025 at 2:17 PM. The Director of Nursing stated it was her expectation that the nursing staff perform hand hygiene in-between each resident during medication pass administration.

3. Documentation on the facility's undated infection prevention and control program policy

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revealed under the heading standard precautions, "Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies."

Documentation under the facility's undated Medication Administration policy revealed under policy explanation and compliance guidelines in part, "14. Remove medication from source, taking care not to touch medication with bare hand."

On 2/14/2025 at 8:39 AM Nurse #3 was observed as she prepared and administered 8 medications to Resident #12. Nurse #3 was observed to put 6 of the 8 medications into her bare hands before putting them in the medication cup and administering the medications to Resident #12.

On 2/14/2025 at 8:54 AM Nurse #3 was observed as she prepared and administered 6 medications to Resident #20. Nurse #3 was observed to put the 6 medications into her hand prior to putting them into the medication cup and then administering the medications to Resident #20.

Nurse #3 was interviewed on 2/14/2025 at 9:04 AM. Nurse #3 stated she used to remove the medication directly from the container into the medication cup, but she was either losing the pills or they were dropping on the floor. Nurse #3 revealed she now put the medication into her hand so that she did not waste or lose medication.

The Director of Nursing (DON) was interviewed on 2/18/2025 at 2:17 PM. The DON stated that a gloved hand could be used to remove pills from a medication card or medication container and then put them into the medication cup. The DON

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F 880	Continued From page 53 explained putting the medication into a gloved hand would keep the medication from being lost or dropped.	F 880		