| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345529 | A. BUILDING _____ B. WING _____ | C 02/24/2025 |

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| E 000 | Initial Comments<br><br>The survey team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 2/21/25 due to adverse weather of snow and unsafe travel conditions; therefore the survey was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25, completed the survey, and exited on 2/22/25. Additional information was obtained remotely on 2/24/25. Therefore, the exit date was changed to 2/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # PM7D11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>The survey team entered the facility on 2/16/25 to conduct a recertification and complaint investigation survey. The survey team was onsite 2/16/25, 2/17/25, and 2/18/25. The survey team was unable to return to the facility on 2/19/25 through 2/21/25 due to adverse weather of snow and unsafe travel conditions; therefore the survey was conducted remotely on 2/19/25 through 2/21/25. The survey team returned to the facility on 2/22/25, completed the survey, and exited on 2/22/25. Additional information was obtained remotely on 2/24/25. Therefore, the exit date was changed to 2/24/25. Event ID # PM7D11.<br><br>The following intakes were investigated: NC00222083, NC00222936, NC00223430, NC00223666, NC00223864, NC00224128, NC00224822, NC00225148, NC00226046, NC00226051, NC00226838, NC00227302, NC00227484, NC00227489, and NC00227583. | F 000 | | |

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

Electronically Signed | 03/19/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 000 | Continued From page 1<br>23 of the 36 complaint allegations resulted in deficiency.<br><br>Immediate Jeopardy was identified at:<br><br>CFR 483.35 at tag F726 at a scope and severity J<br>CFR 483.80 at tag F880 at a scope and severity J<br><br>Immediate Jeopardy began on 2/17/25 and was removed on 2/19/25. | F 000 | | |
| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident and staff interviews, the facility failed to: ensure an independent and unsupervised smoker was able to exit the smoking area to return inside the building without assistance when the designated smoking area was moved to a new location that had a concrete slope from the interior of the facility to the exterior area (Resident #37); and to place a resident's call light within reach to allow the resident to request staff assistance as needed (Resident #12) for 2 of 8 residents reviewed for accommodation of needs.<br><br>Findings included:<br><br>1. Resident #37 was admitted to the facility on 3/1/2024 with diagnoses including stroke and | F 558 | The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F 558<br>1. A doorbell was placed at the smoking area to allow the residents to ring for assistance to get out and to ring if needing assistance 3/19/2025. Resident # 37 demonstrated that he can ring the doorbell for assistance and resident #37 is | 3/25/25 |

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| F 558 | Continued From page 2<br>absence of lower limb.<br><br>Resident #37's care plan included a focus for assistance with activities of daily living dated 8/6/2024 that listed one person assist with transfers as an intervention. The care plan also included a focus for smoking dated 8/14/2024 and interventions included performing smoking assessments as needed.<br><br>A physician progress note dated 9/1/2024 recorded Resident #37 had a left below the knee amputation.<br><br>A smoking assessment dated 9/6/2024 recorded Resident #37 had dexterity problems and indicated Resident #37 could smoke unsupervised. This was Resident #37's most recent smoking assessment.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 11/18/2024 indicated Resident #37 was moderately cognitively impaired and had upper and lower extremity limited range of motion on one side of the body. The MDS further indicated he was dependent on staff to assist with bed to chair transfers and was able to maneuver a manual wheelchair 150 feet.<br><br>On 2/16/2025, a list of independent unsupervised smokers was provided by the Administrator and Resident #37 was listed on the facility's smoking list as an independent unsupervised smoker.<br><br>On 2/16/2025 at 12:35 pm, the previous designated smoking area was observed outside the activities recreation room. The entrance to the covered designated smoking area was through a hinged door from the activities recreation room. | F 558 | also able to navigate the entrance and exit to the smoking area with no issues. Resident # 12 call light was put within his reach.<br>2. Current smokers are at risk<br>3. Administrator to provide education to maintenance staff to make sure the doorbell is in working order. The administrator educated current staff members on answering doorbell when they hear it. Education was completed by 3/20/2025.<br>Any staff member not receiving education will not be able to work until education is completed.<br>The Director of Nursing or designee will educate current staff including agency staff on ensuring call lights are always in reach. Education completed on 3/25/2025.<br>Any staff not receiving education will not be allowed to work until education received including agency staff.<br>Any agency staff will receive education prior to the beginning of their shift.<br>Any new staff member will be educated during the orientation process by the administrator or designee.<br>The maintenance department or designee will audit the doorbell to ensure good working order. Audits will be completed 5x weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2.<br>The Director of Nursing or designee will audit 10 random call lights weekly x 12 weeks then monthly x 2.<br><br>4. Results will be reported by the | |

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| F 558 | Continued From page 3<br>The area from the activities recreation room to the smoking area was flat and the ground outside was made of concrete.<br><br>On 2/16/2025 at 3:14 pm, the new designated smoking area was observed adjacent to the right side of the dining room. The entrance to the new uncovered designated smoking area was through a hinged door that opened into the dining room. There was no push button to automatically open the door. The new uncovered designated smoking area was concrete and there was a slope downward upon entering the designated smoking area.<br><br>On 2/18/2025 at 2:59 pm, an observation and interview was conducted with Resident #37 in the new designated smoking area with family members. Resident #37 was sitting in a manual wheelchair with a left below the knee amputation and a contracted left arm that was rested inward on his waist and a contracted left hand with fingers flexed inward in a fist position. Resident #37 was observed using his right hand to independently smoke with no identified safety concerns. Resident #37 stated he was able to independently open the door to enter and exit the previous designated smoking area outside the activities recreation room. He indicated with the new designated smoking area; he was unable to independently exit the area to return to the interior of the facility due to the slope leading to the doorway. Resident #37 was observed attempting to independently exit the new designated smoking area by using his right foot and right hand to self-propel the wheelchair 180 degrees in the direction of the door that led to the interior of the facility. Resident #37 self-propelled the wheelchair up the slope to the doorway. As he | F 558 | administrator to the quality assurance meeting x3 months for further resolution as needed.<br><br>5. Date of completion: 3/25/2025 | |

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was doing so, his wheelchair was observed to roll backwards requiring the resident to self-propel harder and brace himself with one foot to stabilize himself as he reached the door to return to the interior of the facility. Resident #37 was observed reaching across his body with his right hand in an attempt to open the door. Resident #37 moved the door handle in an upward and downward motion and was unable to push the door open and move the wheelchair forward through the door because he had to brace himself with his right foot to avoid rolling backwards to exit the new designated smoking area independently. Resident #37 was observed returning to the center of the new designated smoking area with family members present.

On 2/18/2025 at 4:32 pm in an interview with Resident #70, who was cognitively intact per the 1/19/2025 MDS, operated an electric wheelchair and was observed in the new designated smoking area with Resident #37 on 2/18/2025 during the previous observation. Resident #70 stated Resident #37 was assisted by his family members back inside the building. Resident #70 stated previously, when they (Resident #70 and Resident #37) were ready to exit the new designated smoking area, he had assisted Resident #37 by pushing the back of Resident #37's wheelchair because Resident #37 was unable to push the door open and move the wheelchair forward through the door as he (Resident #37) had to brace himself with his right foot to avoid rolling backwards.

On 2/18/2025 at 10:30 am, eleven residents attended a Resident Council meeting and reported changing the designated smoking area was a last minute decision that took everyone by

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surprise and the Resident Council was not informed. The residents stated they were not aware of the facility moving the designated smoking area until the staff were moving the smoking items to the new designated smoking area on 2/16/2025.

On 2/18/2025 at 4:45 pm in an interview with Nurse Aide (NA) #13, she stated Resident #37 could self-propel his wheelchair up and down the hallway independently and independently self-propelled the wheelchair out to the new designated smoking area. NA #13 stated she had not observed Resident #37's ability to independently exit the new designated smoking area.

On 2/18/2025 at 4:46 pm an interview was conducted with Resident #37. Resident #37 stated Resident #70 helped push his wheelchair through the door of the new designated smoking area to exit when they were outside smoking at the same time. Resident #37 restated exiting the new designated smoking area was difficult to maneuver independently.

On 2/22/2025 at 12:29 pm, Resident #37 along with other residents were observed smoking in the previous designated smoking area that had a cover overhead. Resident #37 explained the facility was allowing the independent and unsupervised smokers to use the former designated smoking area until the winter weather clears since the new designated smoking area did not have shelter from the weather.

On 2/16/2025 4:38 pm in an interview with the Administrator, she explained there had been concerns about the smoke from the previous

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designated smoking area outside the activities recreation room and she had spoken personally to the residents face to face last week and no concerns were voiced with changing the designated smoking area. She stated as of this afternoon the previous designated smoking area was closed and the new designated smoking area was open that did not have sheltering if raining.

On 2/22/2025 at 1:42 pm in an interview with the Administrator, she stated all smokers in the facility were assessed as unsupervised smokers and independently entered and exited the designated smoking areas. The observation of Resident #37 and the resident's expressed concerns with his inability to independently exit the new designated smoking area without assistance was discussed with the Administrator. The Administrator stated Resident #37 was able to move around the facility independently and she was not aware Resident #37 was having trouble exiting the new designated smoking area. The Administrator stated she had noticed a slope of the concrete at the entrance of the new designated smoking area. She stated there was no assessment of the independent smokers conducted prior to moving the designated smoking area on 2/16/25 to ensure the residents were able to independently enter and exit the area. The Administrator explained smokers were in the former designated smoking area with a shelter on 2/22/2025 because there was a winter snowstorm on 2/19/2025 and 2/20/2025 so they temporarily allowed the resident's to use the previous smoking area because it was covered. The Administrator stated the designated smoking area would move back to the area outside the dining room without a cover and with the sloped

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concrete entrance and exit when the winter weather cleared.

2. Resident #12 was admitted to the facility on 6/21/24 with diagnoses which included type 2 diabetes mellitus, osteoporosis, and hypertension.

Review of Resident #12's care plan dated 7/22/24 revealed a focus area for falls risk due to a need for assistance with transfers and an intervention to place common items within reach of the resident. There was also a focus area for assistance with activities of daily living (ADL) and an intervention for a 2 person transfer and 1 person assist with bed mobility.

Review of Resident #12's quarterly Minimum Data Set (MDS) dated 12/3/24 revealed Resident #12 was cognitively intact. Resident #12 required staff assistance with toileting, hygiene, bathing, and dressing. Resident #12 was dependent upon staff for bed mobility.

During an interview and observation on 2/16/25 at 2:15 pm, Resident #12 was lying in her bed. The call bell was on the floor under the bed on the left side of the bed. When asked where her call bell was she replied, "I don't know". Resident #12 stated she needed her wheelchair to go to the bathroom. Resident #12 further stated she would ask staff who passed by her room for assistance when she could not reach her call bell.

During an interview with Nursing Assistant (NA) #3 on 2/16/25 at 2:39 pm, she stated the call bells were supposed to be within reach of the residents. NA #3 further stated she usually clipped the call bells to the blanket within reach of

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| F 558 | Continued From page 8<br>the resident. She explained she would make sure the call bells were within reach for her residents. NA #3 was not assigned to Resident #12 but assisted Resident #12 immediately. NA #3 indicated Resident #12 could use her call bell and had used her call bell in the past. She indicated the resident was unable to reach the call bell on the floor under the bed.<br><br>A second observation was made on 2/22/25 at 11:00 am with Resident #12. She was lying in her bed with her eyes closed. The call light was wrapped around the bed rail on the right side of the bed out of reach.<br><br>In an interview with NA #4 on 2/22/25 at 3:06 pm, she stated the call bells should be within reach of the resident. NA #4 further stated she clipped the call bell to the resident's blanket or pillow case. NA #4 had worked with Resident #12 and stated she was capable of using the call bell. NA #4 indicated if the call bell was wrapped around the bed rail Resident #12 would be unable to reach it.<br><br>During an interview with the Interim Director of Nursing (DON) on 2/22/25 at 5:00 pm, she stated the staff should be ensuring the call bells are clipped within reach, so they do not fall off the bed. The Interim Director of Nursing indicated Resident #12 was able to activate her call bell; however, she would not be able to reach the call bell if on the floor under the bed or wrapped around the bed rail. | F 558 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. | F 565 | | 3/25/25 |

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| F 565 | Continued From page 9<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews with Resident Council members and staff, and review of the Resident Council minutes, the facility failed to communicate the facility's efforts to address concerns voiced by the Resident Council | F 565 | F565<br>1. Resident council minutes for the last 3 months were audited by the administrator to ensure response and resolution has been implemented. The | |

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| F 565 | Continued From page 10<br>members and to resolve repeat concerns in 3 of 3 months reviewed (November 2024, December 2024, and January 2025) and to maintain evidence that demonstrated the facility's response to grievances/recommendations made by the Resident Council from December 2023 through October of 2024.<br><br>The findings included:<br><br>On 2/18/25 at 8:49 AM, the Administrator revealed the facility had no record of Resident Council minutes from prior to November 2024. The Administrator indicated due to staff turnover they were unable to locate those minutes. Additionally, they had no documented evidence to demonstrate their responses and rationale for such responses for any grievances and recommendations made by the Resident Council prior to November 2024.<br><br>Resident Council minutes dated 11/5/24 indicated residents voiced concerns call lights not being answered timely. The administration resolution section, where the facility's attempts to resolve the concerns from the previous meeting would be documented, was blank. There was no indication of who recorded the meeting minutes.<br><br>A Service Concern Report dated 11/5/24 documented the concerns of the Resident Council related to call light response. The concern form noted nursing staff were educated on answering call bells in a timely manner. The Report noted on 11/6/24 that the status of the concern was "complete." There was no entry in the Disposition by Administration section which would document the follow up on the department manager's response to the grievance and | F 565 | was completed 3/20/2025. Regional activities lead held a resident council meeting on 03/19/2025 to discuss resolution of the items discussed in the previous 3 months. Resolutions of resident council concerns will be provided to the resident council during the following meeting.<br>2. Current Residents have the potential to be affected.<br>3. Administrator provided education to the management team by 03/20/2025 noting response to concerns voiced in resident council meetings are mandatory. Activities director was educated on Activities Policies and Procedures Policy, which states she is to provide the administrator with the original minutes of the Council Meetings along with administrative response to the Resident Council form for review and signature. Education completed by the administrator on 03/20/2025.<br>Any leadership team not receiving education will not be able to work until education received.<br>Any new management team members will receive education during the orientation process.<br>Regional Activity lead or administrator will meet weekly with the Current Resident Council President weekly x 4weeks, then biweekly x4 weeks, then monthly x3 months with monthly review of original minutes of meeting along with administrative response to resident council.<br>4. Results will be reported by the administrator to the quality assurance | |

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| F 565 | Continued From page 11<br>indicate if the resolution of the concerns was ongoing or if the concern was resolved. There was no indication of who completed the Service Concern Report.<br><br>Resident Council minutes dated 12/19/24 revealed call lights not being answered was resolved from the last meeting, but an entry under nursing services noted the repeat concern with call bells being answered timely. Nursing services concerns also noted residents expressed concerns over trouble getting their medications. The minutes also noted dietary concerns of cold food. The administration resolution section was blank. There was no indication of who recorded the meeting minutes.<br><br>A Service Concern Report dated 12/19/24 documented the concerns of the Resident Council related to call light response and cold food. The concern form noted nurse aides were educated on answering call bells in a timely manner and customer service and that the dietary department would "improve their time management." The Resident Council's concerns regarding their medications was not addressed on the concern form. The Report noted on 12/21/24 that the status of the concern was "complete." There was no entry in the Disposition by Administration section indicating if the resolution of the concerns was ongoing or if the concern was resolved. There was no indication of who completed the Service Concern Report.<br><br>Resident Council Minutes dated 1/28/25 completed by the Activity Director noted the council expressed repeat concerns related medications being administered late and call bells not being answered in a timely manner. | F 565 | meeting x3 months for further resolution as needed.<br><br>5. Date of completion: 3/25/2025 | |

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| F 565 | Continued From page 12 | F 565 | | |

An interview was conducted on 2/18/25 at 10:30 AM with the facility's Resident Council. There were 11 residents present. During the meeting, residents expressed concern with the resolution of grievances discussed during the Resident Council meetings. The residents in the meeting reported not all grievances were acted on promptly by the facility and there was no explanation as to why the grievances were not resolved. The residents stated at each meeting they discussed the same concerns. Residents stated the Activity Director was present at the Resident Council meetings and communicated their concerns to the Administration but said they had never heard back from anyone about measures attempted by the facility to resolve their grievances and believed no one was listening to them. Residents stated they continued to have concerns about dietary and food palatability, nurse aide response times, and had requested multiple times for the Administrator and other department heads to come to the meetings themselves and none had come. The residents stated the former Administrator would not meet with residents to discuss any of their concerns and they had the same concerns repeatedly since before the summer of 2024. The residents said the new Administrator was more attentive to the residents but their concerns were still not being addressed.

In an interview on 2/22/25 at 3:31 PM, the Activity Director said when the Resident Council had concerns, a copy of the minutes would be given to the Social Worker. The resolution to the concerns would be communicated back to the council by the Activity Director. She said the call light response time had been an issue for a while

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| F 565 | Continued From page 13<br>but she was unsure what was being done about the issue and she had not reported a resolution to the council because she had not heard of the measures being taken to resolve their concerns.<br>.<br>In an interview on 2/22/25 at 3:03 PM, the Social Worker and the Social Services Assistant said when the Resident Council had concerns, the Activity Director would let the Social Worker know and the Social Worker would write up a grievance concern form. The Social Worker would then let each department know of the concerns for them to follow up and resolve.<br><br>An interview was conducted with the Administrator on 2/22/25 at 6:34 PM who stated since she started in the facility in December 2024, any concerns or grievances from the Resident Council would be reported by the Activity Director to the Social Worker, who would review the next morning in the morning meeting of department heads. Each department head would have 72 hours to resolve and give the resolution back to the Social Worker. The Social Worker or Activity Director would then share the information/resolution at the next Resident Council meeting verbally. | F 565 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; | F 580 | | 3/25/25 |

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| F 580 | Continued From page 14<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations | F 580 | | |

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| F 580 | Continued From page 15<br>under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, Physician interview, and record review, the facility failed to notify the Physician of Resident #25's complaints of pain after an unwitnessed fall for 1 of 4 residents (Resident #25) reviewed for notification of change.<br><br>The findings included:<br><br>Resident #25 was admitted to the facility on 9/24/24.<br><br>Review of Resident #25's quarterly Minimum Data Set (MDS) dated 12/31/24 revealed she was cognitively intact.<br><br>A progress note dated 1/27/25 completed by Nurse #3 revealed Resident #25 was found on the floor lying on her back between her nightstand and her wheelchair and her left knee was bent. Resident #25 denied hitting her head but complained her left knee hurt "pretty bad". The physician was notified. The physician ordered an x-ray of the left knee.<br><br>Review of the neurological checklist dated 1/27/25 completed by Nurse #3 revealed the following:<br><br>At 2:00 pm indicated Resident #25 had verbal expressions of pain and rated the pain as 6 (measured on a 0 to 10 scale with 0 being no pain and 10 being the worst pain).<br><br>At 2:15 pm indicated Resident #25 had verbal expressions of pain and rated the pain as 6. | F 580 | F580<br>1. Resident #25 received an Xray of her left knee on 1/28/205. The provider reviewed the x-ray and sent resident #25 to the emergency room for treatment on 1/29/2025.<br>2. An audit was completed by the Director of Nursing and designee to review the last 7 days of nursing notes to ensure any noted changes in residents□ pain condition were noted and the physician had been notified. This was completed by the Director of nursing on 03/25/2025. The audit included a review of nursing notes and 24-hour shift to shift reports.<br>3. Education initiated by the Director of Nursing and/or designee to current licensed nurses staff including agency staff regarding notification of provider when any noted changes in resident□s pain is observed. Education initiated on 3/19/2025.<br>Any licensed nurse will not be able to work until education received.<br>Agency licensed nurses will receive education prior to the start of their shift by a member of nursing leadership team.<br>New licensed nurses will receive education during the orientation process.<br>4. The Director of Nursing or designee will audit the nursing progress notes for any changes in pain and notification of provider 5 x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 | |

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| F 580 | Continued From page 16<br><br>At 2:30 pm indicated Resident #25 had verbal expressions of pain and rated the pain as 6.<br><br>At 2:45 pm Resident #25 had verbal expressions of pain and rated the pain as 6.<br><br>At 3:15 pm Resident #25 had verbal expressions of pain and rated the pain as 3.<br><br>At 3:45 pm Resident #25 had verbal expressions of pain and rated the pain as 3.<br><br>At 4:15 pm Resident #25 had verbal expressions of pain and rated the pain as 3.<br><br>At 4:45 pm Resident #25 had verbal expressions of pain and rated the pain as 3.<br><br>At 5:45 pm Resident #25 had verbal expressions of pain and rated the pain as 3.<br><br>At 6:45 pm Resident #25 had verbal expressions of pain and rated the pain a 3.<br><br>A 72-hour post fall documentation note dated 1/28/25 at 5:45 pm and completed by Nurse #3 revealed Resident #25 reported pain in her left knee. Nurse #3 obtained an order for x-ray of left knee.<br><br>In a phone interview with Nurse #3 on 2/20/25 at 2:01 pm, she stated she was the nurse assigned when Resident #25 was found on the floor on 1/27/25. Nurse #3 did not remember the nurse aide who reported this to her. Nurse #3 further stated she did neurological assessments on Resident #25 which documented Resident #25 had verbal expressions of pain from 3 to 6 using | F 580 | 5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br>6. Date of completion: 3/25/2025 | |

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| F 580 | Continued From page 17 | F 580 | | |

a numerical pain scale. Nurse #3 explained the facility had a standing order for pain medication. The facility's standing order for pain was Acetaminophen 650 milligrams (mg) every 4 hours as needed for mild pain for 72 hours and to notify physician after 72 hours if pain persisted. Nurse #3 indicated she did not notify the physician of Resident #25's pain and did not have an explanation. She stated she should have notified the physician of Resident #25's complaints of pain on 1/27/25 and on 1/28/25.

A physician's order was obtained on 1/28/25 for an x-ray for Resident #25's left knee and completed by the facility's mobile x-ray unit.

Resident #25's x-ray results of her left knee dated 1/29/25 documented an acute hairline fracture of the left knee with mild swelling noted.

A physician's note dated 1/29/25 revealed he saw Resident #25 for a follow-up visit after an x-ray report noted a hairline fracture of the left knee. Her vital signs were within normal limits. Physical exam noted Resident #25 was awake and alert with decreased mobility and left shoulder painful to touch. Resident #25 was sent to emergency department (ED) for further evaluation.

During a telephone interview on 2/20/25 with Physician # 1, he stated he was aware of Resident #25's fall on 1/27/25 but was not informed by Nurse #3 that Resident #25 complained of left knee pain on 1/27/25 and 1/28/25. He further stated he ordered x-rays of her left knee.

In an interview with the Interim Director of Nursing (DON) on 2/22/25 at 5:00 pm, she stated

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| F 580 | Continued From page 18<br>the nursing staff should have notified the Physician of Resident #25's complaints of pain.<br><br>During an interview on 2/22/25 at 5:00 pm with the Administrator, she stated her expectations of the nursing staff were to notify the Physician when Resident #25 complained of pain. | F 580 | | |
| F 583 SS=D | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. | F 583 | | 3/25/25 |

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| F 583 | Continued From page 19<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to protect a resident's health care information by leaving confidential medical information unattended, visible and accessible to others on the computer screen for 1 of 5 medication carts observed for privacy and confidentiality (100-hall medication cart).<br><br>Findings included:<br><br>During a continuous observation on 2/17/2025 at 5:58 am, Nurse #1 was observed walking away from the 100-hall medication cart located in the hallway with Resident # 43's medical information (name, date of birth, code status and list of six different medications) visible on the computer screen from the 100-hall medication cart positioned five feet from Resident #43's doorway. Nurse #1 was observed entering Resident # 43's room. At 6:00 am, as Nurse #1 returned to the 100-hall medication cart with the computer screen continuing to display Resident #43's medical information, Nurse aide #9 walked by the 100-hall medication cart. Nurse #1 was observed changing the computer screen to Resident #26's medical information (name, date of birth, code status and list of medications) and walking five feet away from the 100-hall medication cart to enter Resident #26's room to take Resident #26's blood pressure. Nurse #1 was called back to the 100-hall medication cart. | F 583 | F583<br>1. Nurse # 1 received education by the Director of Nursing on 3/25/2025 regarding locking screen on computer when not at the computer.<br>2. Current residents have the potential to be affected.<br>3. Education initiated by the Director of Nursing and/or designee to current licensed nurses including agency licensed nurses regarding privacy and the importance of keeping the computer screen locked when not in use. Education was completed on 3/20/2025<br>Any licensed nurse not receiving education will not be allowed to work until education received.<br>Agency licensed nurses will receive education prior to the start f their shift.<br>Any new licensed nurse will receive education during the orientation process.<br>4. The Director of Nursing or designee will audit 5 random nurses on med carts weekly x 12 weeks then monthly x 2.<br>5. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br><br>6. Date of completion: 3/25/2025 | |

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| F 583 | Continued From page 20<br>On 2/17/2025 at 6:02am an interview with Nurse #1 revealed she realized she did not turn the computer screen off to protect Resident #43's and Resident #26's medical information before leaving the 100-hall medication cart. She stated she should have locked the computer screen to hide Resident #43's and Resident #26's medical information before walking away from the 100-hall medication cart.<br><br>On 2/18/2025 at 3:38 pm in an interview with the Director of Nursing, she stated Nurse #1 should have provided privacy to Resident #43's and Resident #26's medical information by turning the computer screen black (locking) so anyone walking by the 100-hall medication cart when Nurse #1 was not present was unable to visualize and read Resident #43's and Resident #26's medical information. | F 583 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for | F 584 | | 3/25/25 |

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| F 584 | Continued From page 21<br>the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and resident and staff interviews, the facility failed to maintain shower floor tiles in good condition on 1 of 3 shower rooms (100-hallway shower room).<br><br>Findings included:<br><br>During a tour of the 100-hallway shower room on 2/16/25 at 3:48 PM, broken floor tiles were observed in the 1st and 2nd shower stalls on the left side of the shower room. Resident #70 was present. He reported he could bathe himself once he was assisted to the shower room. He stated he pulled himself up with the grab bar in | F 584 | F584<br>1. Floor tiles in 100 hall shower room were repaired on 3/19/2025.<br>2. All shower rooms in the center audited by maintenance on 3/19/2025.<br>3. Education was completed 3/19/2025 the maintenance department by the administrator on ensuring the tiles in the shower room are in good condition and not needing repair. Education will be provided to current staff by the maintenance director on entering work orders into the electronic work order portal. Education completed on | |

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| F 584 | Continued From page 22<br>the shower which placed him with his feet directly on the broken shower tiles. Resident #70 stated he had expressed concerns to staff with no results. He stated he could not remember the last time he reported it or to whom.<br><br>An observation was made of the 100-hall shower room 2/16/25 at 4:47 PM. In shower stall #1 there was 11 inches by 14 inches of broken tile below the temperature control and the handrail. In shower stall #2 there was 2 inches by 2 inches of broken tile at the center of the shower under the handrail and shower head.<br><br>An interview was conducted with the Regional Maintenance Consultant on 2/18/25 at 11:41 AM who stated the shower tiles needed to be replaced, and they were a potential hazard to residents when showering. He stated the facility was in the process of hiring a Maintenance Supervisor.<br><br>During an interview with the Regional Housekeeping Consultant on 2/18/25 at 2:06 PM he stated he was unaware of the broken tiles in the 100-hall shower room and none of his staff had mentioned it.<br><br>An interview was conducted with Nurse Aide (NA) #15 on 2/18/25 at 2:42 PM she stated she had not noticed the broken tile in the showers. She reported that there were residents that come into the shower room to take their own shower. NA #15 stated residents who were taking their own shower would likely use the front left side of the shower where the broken tile was located. She stated the facility has not had a maintenance staff member for a few weeks. | F 584 | 3/20/2025.<br>Any maintenance department employees will not be allowed to work until education received<br>Any employee not receiving education will not be allowed to work until education received..<br>Any new maintenance department employees will receive education during the orientation process by the administrator or designee.<br>Any new employee will receive education during the orientation process.<br>4. Audits of all shower rooms will be completed by the maintenance department 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2.<br>Maintenance Director will audit the electronic system for work orders daily x 5 days x 12 weeks then monthly x 2<br>5. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br><br>6. Date of Completion 3/25/2025 | |

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| F 584 | Continued From page 23<br>During an interview with NA #16 on 2/18/25 at 5:23 PM stated she was aware of the broken tiles and had reported it to maintenance staff a few weeks ago. She stated she reported her concern to the maintenance supervisor prior to the last one.<br><br>An interview was conducted with the Director of Nursing (DON) on 2/18/25 at 4:52 PM. She stated she was not aware of the broken tiles in the shower room and none of the staff had advised her.<br><br>Attempts to contact the former Maintenance Director were not successful.<br><br>The Administrator was interviewed on 2/22/23 at 6:26 PM. She stated she was not aware of the broken tiles in 100-hall shower room. The Administrator stated she expected staff to notify maintenance staff of any maintenance concerns. | F 584 | | |
| F 602 SS=E | Free from Misappropriation/Exploitation<br>CFR(s): 483.12<br><br>§483.12<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, and staff, Pharmacist and Pharmacy Consultant interviews, the facility failed to protect the resident's right to be free from misappropriation | F 602 | F602<br>1. Narcotics not in use were returned to the pharmacy on 2/24/2025<br>2. Med Carts were audited on 3/25/2025 | 3/25/25 |

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| F 602 | Continued From page 24<br>of controlled medications. In October 2024, this affected six residents reviewed for misappropriation of property (Resident #232, Resident #109, Resident #87, Resident #81, Resident #16 and Resident #14) and on 2/17/2025, Resident #14's discontinued controlled medications were removed from 300-hall medication cart and not returned to the pharmacy.<br><br>The findings included:<br><br>1. a. Resident #232 was admitted to the facility on 11/15/2023.<br><br>Physician orders dated 7/16/2024 included Oxycodone HCL (an opioid) 5 milligrams(mg) every 4 hours as needed for pain.<br><br>Pharmacy's control medication report recorded Resident #232 was dispensed two separate orders for 90 tablets of Oxycodone HCL 5mg tablet on 9/13/2024.<br><br>The October 2024 Medication Administration Record indicated Resident #232's last dose of Oxycodone HCL 5mg was administered on 10/1/2024 at 4:00 pm by Nurse #10.<br><br>Resident #232 expired on 10/5/2024 in the facility.<br><br>The facility's controlled substance count sheet for medication cart 300-hall recorded 35 controlled substance sheets on 10/5/2025 at 7:00am when Nurse #8 and Nurse #10 counted at the change of shift. Nurse #10 recorded removal of a total of four controlled substance sheets and listed two controlled substance sheets (didn't include the | F 602 | to ensure all narcotics not in use were returned to pharmacy. This was completed by the Director of Nursing and returned as needed.<br>3. Education to licensed nurses including agency to keep narcotics on the med carts until Director or Nursing obtains them to send back to the pharmacy. Education initiated on 3/19/2025.<br>Any licensed nurse will not be allowed to work until education is received.<br>Agency licensed nurses will receive education prior to the start of their shift<br>Any new licensed nurse will receive education during the orientation process by the Director of Nursing or designee.<br>Director of Nursing or designee will complete an audit of each med cart to send narcotics back that are not in use weekly x 12 weeks, then monthly x 2<br>4. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br>5. Date of Completion is 3/25/2025 | |

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name of the controlled medications) removed for Resident #232 with Nurse #14 co-sign signature. The number of controlled substance sheets was recorded as 31 for the 300-hall medication cart on 10/5/2024 at 7:00pm at shift change for Nurse #10 and Nurse #11.

b. Resident #109 was admitted to the facility on 7/1/2024.

Physician orders dated 8/31/2024 included Oxycodone HCL 5 milligrams(mg) every 4 hours for pain as needed.
Resident #109 was not listed on the pharmacy's control medication report as having received any controlled substances in September 2024.

The October 2024 Medication Administration Record indicated Resident #109 received doses of Oxycodone HCL 5mg on the following dates:
-10/1/2024 at 1:20 pm
-10/2/2024 at 1:00 pm
-10/3/2024 at 9:07am
-10/4/2025 at 12:34 pm
-10/6/2024 at 9:32 am
-10/8/2024 at 11:50 pm
-10/9/2024 at 1:08 pm
-10/10/2024 at 12:54 pm

There was no documentation on Resident #109's controlled drug receipt record/disposition form for Oxycodone 5mg of the above medications removed for administration to Resident #109.

Resident #109's control drug receipt record/disposition form for Oxycodone HCL 5mg indicated 60 tablets were accounted for by Nurse #8 and the form stated each dose signed for here requires charting on the medication record. There

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were 17 tablets recorded removed from the Oxycodone 5mg medication card from October 14, 2024 through October 27,2024 and there were only 4 tablets recorded as administered to Resident #109 on Resident 109's October 204 MAR from October 14, 2024 through October 27,2024.

A photo of Resident #109's Oxycodone HCL 5mg medication card dated dispensed 10/13/2024 displayed 50 tablets and bubble slots 51-60 empty on the medication card. On the back side to the Oxycodone HCl 5mg medication card, slots number 10 and 27 were observed as opened and recovered.

c. Resident #87 was admitted to the facility on 9/21/2023.

Resident #87's physician orders dated 9/04/2024 included Oxycodone HCL milligrams (mg) tablet take one to two tablets every four hours for pain.

Pharmacy's control medication report recorded Resident #87 was dispensed 30 tablets of Oxycodone HCL 5mg tablet on 9/4/2024.

A photo of Resident #87's Oxycodone HCL 5mg medication card dated dispensed 9/4/2024 displayed 30 tablets and bubble slots 30 empty and reported bubble slot number 5 empty/missing on the medication card. On the back side to the Oxycodone HCl 5mg medication card, slot number 30 was opened and number 5 was recovered.

Resident #87's control drug receipt record/disposition form for Oxycodone HCL 5mg indicated 30 tablets were accounted for and the

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form stated each dose signed for here requires charting on the medication record. There was one tablet recorded removed from the Oxycodone 5mg medication card on 9/23/2024.

Resident #87's September 2024 Medication Administration Record (MAR) recorded three doses of Oxycodone HCL 10mg were administered to Resident #87 on 9/6/2024, 9/9/2024 and 9/10/2024. There was no documentation on the September 2024 MAR that Resident #87 received a dose of Oxycodone HCL 5mg on 9/23/2024.

d. Resident #81 was admitted to the facility on 7/6/2023.

Physician orders dated 6/30/2024 included Oxycodone HCL 5 milligram (mg) every six hours as needed for pain.

A photo of Resident #81's Oxycodone HCL 5mg medication card dated dispensed 10/13/2024 displayed 57 tablets and bubble slots 58-60 empty and reported bubble slot number 27 and 18 as empty/missing on the medication card. On the back side to the Oxycodone HCl 5mg medication card, slot number 18 and 37 were recovered.

Resident #81's control drug receipt record/disposition form for Oxycodone HCL 5mg indicated 50 tablets were accounted for on 9/26/2024 and the form stated each dose signed for here requires charting on the medication record. There were 40 tablets total recorded removed from the Oxycodone 5mg medication card with a zero balance on 10/16/2024. There were 10 Oxycodone 5mg tablets unaccounted for

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on Resident #81's control drug receipt record/disposition form.

Resident #81's October 2024 Medication Administration Record (MAR) recorded 22 doses of Oxycodone HCL 5mg were administered to Resident #87 from 10/1/2024 through 10/22/2024. There was 10 doses not recorded on the October 2024 MAR documented as removed from Resident #81's control drug receipt record/disposition form for Oxycodone HCL 5mg. There were three doses recorded as given on the October 2024 MAR that were not documented as a removal on Resident #81's control drug receipt record/disposition form for Oxycodone HCL 5mg.

e. Resident # 16 was admitted to the facility on 6/17/2024.

Physician orders dated 8/30/2024 included Oxycodone 5 mg every six hours as needed for pain.

A photo of Resident #16's Oxycodone HCL 5mg medication card dated dispensed 10/13/2024 displayed 18 tablets and bubble slots 19-30 empty and reported bubble slot number 4 and 14 as empty/missing on the medication card. On the back side to the Oxycodone HCl 5mg medication card, slot number 4 and 14 were recovered.

Resident #16's control drug receipt record/disposition form for Oxycodone HCL 5mg indicated 30 tablets were accounted for on 10/13/2024 and the form stated each dose signed for here requires charting on the medication record. There were 12 tablets total recorded removed from the Oxycodone 5mg medication card with 18 as the balance on 10/18/2024.

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Resident #16's October 2024 Medication Administration Record (MAR) recorded a total of 2 doses of Oxycodone HCL 5mg were administered to Resident #87 on 10/14/2024 (1 dose) and 10/16/2024 (1 dose). There was 10 doses not recorded on the October 2024 MAR that were documented as removed from Resident #16's control drug receipt record/disposition form for Oxycodone HCL 5mg.

f. Resident #14 was admitted to the facility on 2/7/2023.

Physician orders dated 7/1/2024 included Oxycodone HCL 5 milligram (mg) tablets one every six hours as needed for pain.
A photo of Resident #14's Oxycodone HCL 5mg medication card dated dispensed 9/13/2024 displayed 18 tablets and bubble slots 19-30 empty and reported bubble slot number 4 and 14 as empty/missing on the medication card. On the back side to the Oxycodone HCl 5mg medication card, slot number 4 and 14 were recovered.

Resident #14's control drug receipt record/disposition form for Oxycodone HCL 5mg indicated 90 tablets were accounted for on 9/13/2024 and the form stated each dose signed for here requires charting on the medication record. There were 58 tablets total recorded removed from the Oxycodone 5mg medication card with 32 as the balance on 10/18/2024.

Resident #14's September 2024 Medication Administration Record (MAR) recorded a total of 2 doses of Oxycodone HCL 5mg were administered to Resident #14 on 10/25/2024 (1 dose) and 10/29/2024 (1 dose). There were 26

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doses not recorded on the September 2024 MAR that were documented as removed from Resident #14's control drug receipt record/disposition form for Oxycodone HCL 5mg.

Resident #14's October 2024 Medication Administration Record (MAR) recorded a total of 7 doses of Oxycodone HCL 5mg were administered to Resident #14 on 10/1/2024 through 10/16/2024. There were 25 doses not recorded on the October 2024 MAR that were documented as removed from Resident #14's control drug receipt record/disposition form for Oxycodone HCL 5mg.

The facility submitted an initial allegation report dated 10/22/2024 signed by the former Administrator reporting a diversion of facility drugs to the state agency. The initial allegation report stated the facility became aware of the incident on 10/17/2024 at 2:40 pm and reported the incident occurred between 9/3/2024 and 9/17/2024. The initial allegation report stated during a shift change an in-coming licensed nurse identified that Oxycodone 5mg (an opioid/pain medication) medication cards for three different residents were tampered with. The Oxycodone tablets in the medications cards had been replaced with a different medication that resembled oxycodone to make the count deem correct. The total of 27 tablets of oxycodone 5mg were missing. All three residents have no signs of pain or discomfort.

The facility reported that the local police department was notified of the incident on 10/22/24 at 2:40 pm.

The facility's investigation summary completed on

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10/28/2024 by the former Administrator reported that on 10/22/2024, the facility's Director of Nursing (DON) and the Unit Coordinator inspected the controlled medications cards in all the medication carts in the facility to identify any other medications cards that were tampered with. Two other residents' controlled medication cards were identified as having been tampered with, with three tablets of Oxycodone replaced with another tablet that resembled oxycodone 5 mg. The total of oxycodone 5mg tablets missing was identified as 30 tablets. On 10/22/2024, the DON reviewed the controlled medications that were to be returned to the pharmacy for disposal and identified two oxycodone 5mg medication cards for Resident #232 were missing. When the DON contacted Nurse #8 who removed the missing cards from the medication cart to return to the DON, Nurse #8 told the DON she misplaced the medication and did not know where she put them. A review of the controlled substance count sheet indicated Nurse #8 signed the two medication cards out of the medication cart and was co-signed by the weekend supervisor Nurse #12. The DON interviewed Nurse #12, who stated she did not co-sign with Nurse #8. When the DON showed Nurse #12 the signature on the controlled substance count sheet and Nurse #12 disputed that she did not sign the form and indicated that the signature was created by another person. Narcotic count sheets indicated Nurse #8 worked on both medication carts with tampered medications cards and missing medication cards. The tampered medication cards were for oxycodone 5 mg, the same medication that Nurse #8 lost the two medication cards for Resident # 232 and forged a co-signature. The DON contacted Nurse #8 about the tampered medication and forged signature on 10/23/2024

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and 10/24/2024. Nurse #8 refused to be interviewed and chose not to respond when asked to report to the facility for a drug screening. Nurse #8 was an agency employee who periodically worked in the facility from 8/21/2024 to 10/14/2024. Nurse #8 will no longer be allowed to work at the facility. The facility concluded based on circumstantial evidence (forged signature, missing oxycodone 5mg medication cards and tampered of the oxycodone medication cards) there was reasonable suspicion that Nurse #8 diverted Oxycodone 5mg tablets for 6 residents (Resident #232, Resident #109, Resident #87, Resident #81, Resident #16 and Resident #14). The facility reported Nurse #8 to the North Carolina Board of Nursing on 10/28/2024. Licensed nurses and medication aides were re-educated on the importance of inspecting the medication cards to ensure they were not tampered with.

The facility's investigation report dated 10/28/2024 signed by the former Administrator was submitted to the state agency. The investigation report recorded the Department of Social Services (DSS) was notified on 10/22/2024 with no on-site visit from DSS and there were no charges filed against the accused individual.

On 2/17/2025, the facility's folder for October 2024 misappropriation of controlled medications was reviewed. There was documentation of sixteen nurses on 10/23/2024 attending an educational in-service conducted by the former DON on inspection of controlled medication card and destruction of controlled medications in the dry drug buster requiring two nurse witness and signage.

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There was no documentation of resident assessments related to pain management with confirmed tampering of controlled medications.

There was no documentation of the nursing staff education on the changes in adding and removing controlled medications from the medication carts and the DON returning controlled medications to the pharmacy.

There was documentation of random weekly control medication audits conducted on one resident one controlled medication per week by the former DON on 12/10/2024, 12/12/2024, 12/19/2024, 12/28/2024. There were no missing tablets on the controlled medication cards. There was missing entries on the controlled medication sheet on 12/28/2024 (CF) and crossed out and/or changed entries on 12/12/204, 12/19/20 and 12/28/24 for 2 residents. The December 2024 audits were marked as reviewed in QAPI on 12/18/2024.

Unit Manager #1 conducted random audits in January 2025 (1/8/25, 1/14/25, 1/19/25, 1/15/25 and 1/27/25) one resident per day audited with no missing entries on controlled medication sheet, crossed out or changed entries or missing tablets on medication card. The January 2025 audits were not signed as reviewed in QAPI.

On 2/17/2025 at 5:30 pm, when asked if there was a corrective action plan, the facility provided corrective action plan for the misappropriation of controlled medications.

On 2/24/2025 at 9:09 am in an interview with Nurse #13, she stated she could not recall the exact date in October 2024 when counting

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controlled medications at the change of shift with Nurse #8. She stated Nurse #8 brought it to her attention the tablets in a medication card of oxycodone didn't look right. When the medication card was removed, there were tablets that look similar but not exactly like the controlled medication and there was tape observed on the back of the medication card over some of the bubble slots of the medication card. She stated the acting Administrator was notified. She stated when all residents' controlled medication cards were checked for tampering, correct count and correct medication, there were more residents' medication cards observed with tampering and/or missing controlled medications. Nurse #13 was unable to recall the names of the residents who controlled medication cards were affected. She stated the facility change the process of counting and removing controlled medications from the medications cart after the incident in October 2024. She explained the changes as: (1) when counting controlled medications inspect the back of the medication cards and tablets for suspicion of tampering, (2) adding and/or removing controlled medications to a medication cart required another nurse to count and sign with the nurse and (3) discontinued controlled medications were to remain on the medication cart and when the Director of Nursing removed the controlled medications to return to pharmacy, a nurse would count and sign with the DON.

On 2/22/2025 at 4:17 am in a phone interview with Nurse #8, she stated prior to October 17, 2024 the night nurses returned discontinued controlled medications to the pharmacy by completing return to pharmacy form, place in pharmacy tote, secure with zip tie and return to pharmacy when medications were delivered at

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night. Nurse #8 stated she was not given Resident #232's controlled medications to return to the pharmacy in October 2024. She stated since October 2024, the process to receive and return controlled medications had changed. She explained two nurses have to count and sign controlled medications when added to the medications cart and/or removed to return to pharmacy. She stated nurses on the medications carts let the DON know when there were discontinued medications on the medication carts and DON was responsible for returning medications to the pharmacy now.

On 2/24/2025 at 10:26 am in a phone interview with Nurse #8, she recalled in October 2024 while counting controlled mediations with another nurse (unable to recall name), the back of a controlled medications card was observed tampered with. She described the tampering as a tiny slit that had been made in the back of the bubble slot on the controlled medication card, there was a tablet in the bubble slot and a piece of tape was covering area where the slit was made. She stated the tablet inside looked similar to the controlled medication and questioned the medication because there was a number on the tablet. She stated the acting Administrator was at the facility and informed. She stated all controlled medications were counted for accuracy and assessed for tampering and drug test were performed on nursing staff. She explained after October 2024, two nurses counted and signed when adding controlled medications to the medications cart and the DON was the only person that could remove controlled medications from the medication cart to return controlled medications to the pharmacy.

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On 2/16/2025 at 5:44 pm in an interview with Nurse #14, she explained she was the weekend supervisor and had worked at the facility since February 2018. She stated controlled medications were stored in a double locked drawer on the medications carts and two nurses were to count and sign the controlled medications records when adding controlled medications to the medication cart. She stated controlled medications were counted by two nursing staff at the change of the shift and when controlled medications counts were not correct the supervisor was notified to determine the reason the count was incorrect and notified the DON if unable to determine why the controlled medication was inaccurate. She stated she did not recall in October 2024 reports of inaccurate controlled medication counts. She explained she rarely worked during the week and in October 2024 when there was a concern with controlled medications on the medication carts. She recalled receiving a call from the former DON asking where the controlled medications for Resident #232 were located. She stated she remembered Resident #232 dying on a weekend (unsure of the date) and Nurse #10 having Resident #232's three controlled medications cards that consisted of two controlled medications cards for oxycodone and one controlled medication card for Lorazepam asking her what she needed to do with Resident #232's controlled medications cards. She stated she verified the count on the controlled medications sheets and the controlled medication cards with Nurse #10, and the controlled medication sheet was marked with an x symbol. She stated she informed Nurse #10 to give the controlled medications to the night nurse to return the medications to the pharmacy. She explained discontinued controlled medications remained on

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the medication cart and were counted at the change of each shift until returned to the pharmacy. She said on 10/19/2025 the former DON called inquiring where Resident #232's controlled medications were located because Nurse #10 had signed the controlled substance count sheet recording Resident #232 controlled medications had been given to her (Nurse #14). She stated she told the former DON Nurse #10 had been informed to give the discontinued controlled medications to the night nurse to return to the pharmacy and she (Nurse #14) had not signed a controlled substance sheet or received Resident #232's controlled medications. She stated she reviewed the signed controlled substance count sheet and that was not her signature on 10/5/2024 when Resident #232's controlled medications were documented removed from the 300-hall medication cart.

Attempts to interview Nurse #10 were unsuccessful.

On 2/17/2025 at 4:12 pm in a phone interview with Unit Manager #1, she stated she was unable to recall the date and recalled reporting to work that morning and at nursing station #2 controlled medications were observed tampered with when counting the controlled medications and the former DON was notified. She stated the acting Administrator was present and the nurses who had worked at nursing station #2 were drug tested. She stated the facility did not drug test everyone. She stated she and the acting Administrator checked all the controlled medications on the medications carts for accurate count and tampering of controlled medications. She reported the controlled medication, Oxycodone, for Resident #232 was not located.

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She explained that the nursing staff were not sending residents' controlled medications back to the pharmacy and controlled medications were remaining on the medication carts long after discontinuation of the controlled medications. She stated on 10/22/24 when she and the former DON conducted a facility wide audit on the controlled medications, tampering was observed with Resident #87' controlled medications and the controlled medications were replaced by the pharmacy. She stated the residents affected with tampering of the controlled medications were assessed by the former DON and nurses. She stated the nursing staff was educated on the changes in the controlled medication sheet, documenting all controlled medications administered and non-controlled scheduled medications in the electronic MAR and documenting controlled medications removed on the controlled medication sheet. She stated the nursing staff were further educated on the changes that two nurses were required to count and sign when controlled medications were added and/or removed from the medication carts and the DON would be responsible for returning controlled medications to the pharmacy.

On 2/21/2025 at 5:25 pm in a phone interview with Pharmacist #1 and Pharmacist Consultant #1, they stated the Pharmacy Director of Clinical Services worked with the facility in October 2024 related to misappropriation of controlled medications and the person in that position no longer worked at the pharmacy. Pharmacist #1 stated there was no record in the pharmacy that Resident #232 controlled medication, Oxycodone, was returned to the pharmacy.

On 2/24/2025 at 9:29 am in a phone interview

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with the Pharmacist Consultant #1, she stated due to the turnover in the Director of Nursing position, the pharmacy consultants had been providing education to the DON on the process of returning controlled medications using the return to pharmacy triple form to list the controlled medications and using the red pharmacy totes to return controlled medications to the pharmacy. She stated on 1/5/2025 a medication inspection was performed at the facility and there were no controlled medications observed to return to the pharmacy.

On 2/22/2025 at 1:56 pm in a phone interview with the former Director of Nursing, she remembered receiving a call about tampered controlled medication cards discovered by Nurse #13. Unit Manager #1, who was at the facility, conducted an audit on all controlled medications on the medication carts and removed all the tampered controlled medications cards off the medications carts and were replaced by the pharmacy. She stated the controlled medications for Resident #232 were not located. She stated nurses were drug tested with negative results reported and one nurse did not return for a drug test or work and was reported to the N.C. Board of Nursing. She stated residents' assessments for pain management was completed and the nursing staff received education on accuracy accounting for controlled medications when receiving and removing controlled medications for the medication carts. She stated it was changed to the DON would be responsible in returning controlled medications to the pharmacy and stated controlled medications were to be returned within 24-48 hours and not remain in the facility. She stated the nursing staff receiving educational training on two nurses counting and signing for

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controlled medications when adding and removing controlled medications to the medication carts and counting the number of controlled medications cards and the actual number of tablets in each controlled medication card sheet at the change of the shift. She stated another audit of all controlled medications on the medication carts were conducted a week later and further tampering of resident controlled medications. She stated there were ongoing audits conducted on controlled medications on the medication carts conducted and the information was discussed in Quality Assurance and Performance Improvement (QAPI) meetings.

On 2/22/2025 at 1:33 pm in a phone interview with the former Administrator, she stated when a concern with misappropriation of controlled medications was identified by Nurse #13, all controlled medications on the medication carts were audited and further discovering of tampering of controlled medications were identified. Residents' controlled medications were replaced and nursing staff were educations of the changing in adding and removing controlled medications to the medication cart. Residents were interviewed with no negative findings related to pain. She explained there was a plan of correction and should be in the QAPI minutes for October 2024. She stated the Assistant Administrator in October 2024 would have more information on the plan of correction.

On 2/22/2025 at 2:32 pm in a phone interview with the former Assistant Administrator, she stated she was left the facility in October 2024 after the incident with misappropriation of controlled medications. She stated the Administrator and Regional Clinical Consultant

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addressed the concern. She stated she was not sure there was a plan of correction.

On 2/24/2025 at 10:50 pm in a phone interview with Regional Clinical Consultant, he explained due to the facility's history with diversion of controlled medications there had been a plan of correction in place and the facility continued with the plan of correction in October 2024 when controlled medications cards were found at the change of shift tampered with. He explained that the facility was only counting the number of controlled medication cards and were not actually counting the number of pilling in the controlled medication cards. New practices included counting the number of controlled medication cards and the actual count for each controlled medication card on the medication cart at the change of each shift, inspecting the back of the controlled medications cards and controlled medication sheet for each medication cart required two nurses to count and sign when controlled medications were added and removed from the medication cart. He stated the DON only was to remove controlled medications from the medication carts to return controlled medications to the pharmacy Monday through Friday. He stated controlled medications that remained on the medication carts were counted at the change of the shift on the weekends to be returned to the pharmacy by the DON on Monday. He stated when tampering with controlled medications were identified on 10/22/2024, all medications carts where audited, nurse staff were educated on counting controlled medications and the process for removing controlled medications from the medication cart. He stated Nurse #10 was reported to the North Caroline Board of Nursing due to suspicion of misappropriation of controlled

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medications and audits were conducted on the new process for controlled medications and reviewed in Quality Assurance and Performance Improvement (QAPI) meetings.

On 2/22/2025 at 1:10 pm, when asked for a second time, the facility was unable to provide a corrective action plan for misappropriation of property related to controlled medications.

2. Resident #14 was admitted to the facility on 2/7/2023.

Resident #14 died on 2/16/2025.

Physician orders dated 2/15/2025 at 5:48 pm included oxycodone HCL (an opioid) 10 milligrams(mg) tablets; take two tablets every six hours as needed for pain. There was a previous order dated 1/21/2025 for oxycodone HCL 10mg one tablet every six hours for pain as needed that was discontinued on 2/17/2025. Physician orders also included the controlled medications: Morphine sulfate concentrate solution (an opioid) 100mg per 5 milliliters with instructions to give 0.25 milliliters every three hours as needed for moderate to severe pain or shortness of breath on 11/8/2024 and Lorazepam (antianxiety medication) 0.5mg every six hours as needed for anxiety.

A review of the February 2025 Medication Administration Record indicated Resident #14 received Oxycodone 10mg two tablets on 2/15/2025 and 2/16/2025. Oxycodone 10mg was administered on for a total of eleven doses from 2/1/2025 to 2/14/2025.

On 2/17/2025 at 7:17 am, an interview and

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observation was conducted. Medication aide #4 and Nurse #15 were observed counting the controlled medications at the change of shift narcotic count for the 300-hall medication cart. The following controlled medications were on the 300-hall medication for Resident #14: one Oxycodone 10mg controlled medication card with 35 tablets verified with the controlled medication sheet, oxycodone 5mg controlled medication card with 20 tablets verified with the controlled medication sheet, Lorazepam 0.5mg controlled medication card with 3 tablets verified with the controlled medication sheet and a bottle of Morphine Sulfate solution with 13.5 milliliters verified with the controlled medication sheet. Medication Aide #4 stated controlled medications were returned to the pharmacy at night and the pharmacy did not deliver medications on Sunday (2/16/2025). She stated the unit managers removed the controlled medications off the medication carts and completed the return to pharmacy form to return controlled medications to the pharmacy.

A review of the controlled substance count sheet for 300-hall medication cart on 2/24/2025 recorded three controlled medication cards for Resident #14 were removed on 2/17/2025: Oxycodone 5mg, Oxycodone 10mg and Lorazepam 0.5mg and the initials of the Director of Nursing (DON) as the person that removed the controlled medications.

On 2/20/2025 at 4:30 pm an interview was conducted with the DON, who resigned on 2/19/2025. During the interview the DON informed the surveyor there were controlled medications in a filing cabinet behind the locked door of the DON's office. No further information

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was obtained in the interview.

On 2/22/2025 at 4:10 pm in a phone interview with Interim Director of Nursing, she stated she had not received Resident #14's oxycodone medication card from the 300-hall medication cart from any nursing staff. She stated she understood unit managers were removing controlled medications off the medication carts and giving them to the DON, who was responsible for ensuring controlled medications were returned to the pharmacy. The Interim DON stated Resident #14's controlled medications should have been removed from the 300-hall medication cart and returned to the pharmacy immediately after Resident #14's death.

On 2/22/2025 at 4:14 pm and interview and observation was conducted with Nurse #4. Nurse #4, who was assigned the 300-hall medication cart, stated Resident #14's Oxycodone and Lorazepam controlled medication cards were not on the medications cart and the DON would have removed the controlled medications from the 300-hall cart to return the controlled medications to the pharmacy. With Nurse #4, the controlled medications and controlled medications sheet on the 300-hall medication cart were observed. There were no controlled medication cards observed on the 300-hallmedication cart. There was one controlled medication sheet for Morphine Sulfate solution and a bottle of Morphine Sulfate solution observed on the 300-hall medication cart. Resident #14's Morphine Sulfate of 13.5 milliliters was listed on the controlled medication sheet and observed in the bottle.

On 2/22/2025 at 4:30 pm, the Administrator and Corporate Nurse Consultant #1 accompanied the

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surveyor to the DON's office for an observation of the filing cabinet in the DON's office. The DON's office was observed located on a short hall from nursing station #1 beside the residents' shower room. The Administrator was observed unlocking the door to the DON's office. There was one filing cabinet that was located behind the DON's desk in the DON's office. The filing cabinet drawers were found to be unlocked and the Administrator stated the filing cabinet did not have a lock. Controlled medications were observed removed by the Administrator from the third drawer from the top of the unlocked filing cabinet and verified with Corporate Nurse Consultant #1 that included Resident #14's Lorazepam 0.5 mg three tablets in the medication card. There was no controlled substance sheet for Resident #14's Lorazepam to verify the count was accurate. There were no oxycodone controlled medication card or controlled substance sheets for Resident #14 located in the DON's filing cabinet

On 2/24/2025 at 7:39 am in a phone interview, the Administrator was informed of the concern of misappropriation of Resident #14's controlled medication, Oxycodone.

On 2/24/2025 at 7:50 am in a phone interview with the DON, she could not recall removing Resident #14's controlled medications and controlled medications sheet off the 300-hall cart on 2/17/2025. She remembered on 2/16/2025 with the help of Unit Manager #1, Unit Manager #2 and the Assistant DON collecting all discontinued controlled medications from all the medications carts when the recertification survey started and on 2/17/2025 and stated on 2/18/25 nursing staff randomly gave her discontinued controlled medications off the medications cart.

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She stated the controlled medications were wrapped in the controlled medications sheets and did not know whose controlled medications she had received. She stated due to the nursing staff handing her controlled medications while she was walking in the hall to complete another task, she did not sign the controlled substance count sheet. She stated she placed the controlled medications in the filing cabinet (that could not be locked) in the DON's office until she could return the controlled medications to the pharmacy. She stated she had not been instructed how to return controlled medications to the pharmacy. She stated due to being busy with the survey, she had not returned the controlled medications to the pharmacy and there would have been times she would have stepped across the hall to Unit Manager #1's office with the DON's office door open.

On 2/24/2025 at 8:11 am in a phone interview with Unit Manager #1, she explained she would remove discontinued controlled medications off the medications carts and give them to the DON directly to return to the pharmacy. She stated she knew the DON kept controlled medications in her office until she could send the controlled medications back to the pharmacy. She stated none of the nurses assigned the 300-hall medication cart had not given her Resident #14's controlled medications and she had not removed Resident 14's controlled medications from the 300-hall medication cart. She explained two nurses were to count and sign when controlled medications were removed from the medication cart.

On 2/24/2025 at 8:49 am in a phone interview with Unit Manager #2, she stated she had been

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out of work since 2/15/2025 and returned to work on 2/21/2025. She stated no one had given Resident #14's controlled medication cards to her to give to the DON to return the controlled medications cards to the pharmacy.

On 2/24/2025 at 12:28 pm in a phone interview with Medication Aide #4, she stated Resident #14's Oxycodone was still on the 300-hall medication cart on the morning of 2/17/2025 when she left from the 7:00pm to 7:00am shift.

On 2/24/2025 at 12:25 pm in a phone interview with Nurse #4, she stated when she was assigned the 300-hall medication cart on 2/21/2025 and 2/22/2025, Resident #14's Oxycodone medication card and the controlled substance sheets for Oxycodone were not on the 300-hall medication cart and she did not know where they were located. She stated Resident #14's controlled medication, Morphine Sulfate, remained on the 300-hall medication cart.

On 2/24/2025 at 9:38am in a phone interview with Nurse #15, she stated the DON removed discontinued controlled medications from the medications carts to returned the controlled medications to the pharmacy and DON removed Resident #14 controlled medications, Oxycodone 10mg and 5mg medication cards off the 300-hall medication cart on 2/17/2025. She recalled signing that the count on the Oxycodone 10mg and 5mg substance sheets were accurate. Stated she did not sign the control substance count sheet that the controlled medication sheets were removed.

On 2/24/2025 at 10:33 am in a phone interview with Unit Manger #1, she stated there was a

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controlled substance count sheet at the front of the controlled medication book on each medication cart. She explained when controlled medications were removed by the DON from the medication cart, the DON and a nurse were to count and signed the controlled medication count was accurate and removed.

On 2/24/2025 at 9:44 am in a phone interview with the Pharmacist #1, he stated the DON was informed of the process of how to return controlled medications that were to be returned to the pharmacy and not to be destroyed at the facility. He explained the process as: list the controlled medications on a return to pharmacy triple form, place one copy of the triple form with the controlled medications in the red pharmacy tote, use controlled medication zip tie to secure red tote and write number of the zip tie on the return to pharmacy triple form. He stated pharmacy picked up the red pharmacy tote when delivering medications Monday through Saturday and the controlled medications were verified with the controlled medications listed on the return to pharmacy triple form. He stated the DON was to retain the other two copies of the return to pharmacy triple form. He further stated Resident #14's Oxycodone had not been returned to the pharmacy.

On 2/24/2025 at 9:56am in a phone interview with the Administrator, she stated that when the DON resigned on 2/19/2025, the DON reported there were narcotics in the filing cabinet of her office. She explained the Lead Administrator and herself went to the locked DON office and visually saw the controlled medications were in the unlocked filing cabinet drawer and did not count the controlled medications. She stated she requested

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maintenance to change the lock to the DON office that was completed by noon on 2/19/2025 and the Administrator was given the only key to the locked DON office. The Administrator explained she was still learning the process at the facility for returning controlled medications to the pharmacy and understood there was a pharmacy form that listed the controlled medications being returned to the pharmacy that was completed and signed by two nurses and accompanied the controlled medications that were placed in a red locked pharmacy tote that was picked up by pharmacy when delivering medications.

On 2/24/2025 at 12:41 pm in an interview with the Regional Maintenance Director, he stated the Administrator requested the lock to the DON's office to be changed on 2/19/2025. He stated he installed a new lock on the DON office door around 12:00pm. He stated he conducted the work by himself and no one entered the DON's office while he changed the lock. He stated the Administrator was provided the key to the DON office and no one else had a key to the DON office.

On 2/24/2025 at 12:24 pm in a phone interview with Pharmacist #1, he stated the controlled medications returned from the facility on 2/24/2025 included Resident #14's controlled medications, Lorazepam and Morphine Sulfate. He stated Resident #14's Oxycodone 10 mg tablets had not been returned to the pharmacy.

On 2/24/2024 at 2:23pm in a phone interview with the Administrator, she stated Resident #14's controlled medication, oxycodone, should have been returned to the pharmacy per the facility's policy and practice and the facility would conduct

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| F 602 | Continued From page 50<br>an investigation. | F 602 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; | F 623 | | 3/25/25 |

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(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy

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| F 623 | Continued From page 52<br>for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to provide a written notice of transfer and/or discharge to the resident and the resident representative for 1 of 1 resident reviewed for hospitalization (Resident #90).<br><br>Findings included:<br><br>Resident #90 was admitted to the facility on 1/21/2025 with diagnoses included Alzheimer's disease.<br><br>The admission Minimum Data Set (MDS) assessment dated 1/28/2025 indicated Resident #90 was moderately cognitively impaired.<br><br>The discharge MDS assessment dated 2/9/2025 indicated Resident #90 had an unplanned | F 623 | F623<br>1. Resident # 90 was provided with a copy of the transfer discharge notice<br>2. An audit was completed by the Director of Nursing of the last 7 days of unplanned discharges to ensure that the written transfer discharge notice was provided. This was completed on 3/20/2025.<br>3. Education was initiated by the Director of nursing or designee to the current licensed nurses including agency licensed nurses on the procedure to send transfer discharge agreement upon transfer to the hospital. This was initiated on 3/19/2025. Any new licensed nurse will not be allowed to work until education has been received. Agency licensed nurses will | |

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| F 623 | Continued From page 53<br>discharge to a hospital, and Resident #90's was anticipated to return to the facility.<br><br>Nursing documentation on 2/9/2025 at 6:15 pm by Nurse #7 recorded Resident #90 was discharged from the facility to the hospital at the request of Resident #90's family member, and Resident #90's face sheet, medication list and medical orders for scope of treatment (MOST) form was given to the emergency medical services (EMS) personnel. There was no documentation that a written notice of transfer and/or discharge was given to the resident and their representative.<br><br>On 2/22/2025 at 1:02 pm in an interview with Nurse #2, who acted as a shift supervisor, she stated the nursing staff completed the electronic transfer form that reported the resident's condition and notification of the physician and resident representative when a resident was transferred out of the facility. Nurse #2 stated she was not familiar with a written notice of transfer and/or discharge form to give to residents and their representative when transferred or discharged from the facility.<br><br>On 2/22/2025 at 4:04 pm in an interview with the Interim Director of Nursing, she stated she did not know who was responsible for completing the written notice of transfer and/or discharge at the facility and suggested the Social Worker would have completed Resident #90's written notice of transfer and/or discharge form.<br><br>On 2/22/2025 at 4:18 pm in an interview with the Social Worker, she stated the nursing department was responsible for completing Resident #90's written notice of transfer and/or discharge form. | F 623 | receive education prior to the start of their shift.<br>Any new licensed nurse will receive education on the orientation process.<br>The Director of Nursing or designee will audit the hospital transfers during the morning clinical meeting 5 x weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2.<br>4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br>5. Date of completion: 3/25/2025 | |

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| F 623 | Continued From page 54<br><br>On 2/22/2025 at 8:50 pm in an interview with Corporate Nurse Consultant #1, she stated the nursing department was responsible for completing the written notice of transfer and/or discharge form to give to residents and their representative. She explained there was a packet that the nursing staff generated at the time of transfer and/or discharge that included the written notice of transfer and/or discharge to give to the resident. | F 623 | | |
| F 641 SS=E | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Pre-Admission Screening and Resident Review (PASARR) (Resident #17, Resident 67, and Resident #4), use of opioid pain medication (Resident #14), schizophrenia (Resident #41) and anticoagulants (Resident #10) for 6 of 54 residents whose MDS assessments were reviewed.<br><br>Findings included:<br><br>1. Resident #17 was admitted to the facility on 7/4/23 with diagnoses that included depression and dementia.<br><br>Resident #17's care plan included a focus for dementia and PASARR. Interventions included | F 641 | F641<br>1. Modifications to the Minimum Data Set were made to residents #53, 17,67,4, 14 and 10.<br>2. Current residents at risk for inaccurate MDS coding. MDS coordinator audited all level II PASARR patients to ensure the PASARR was accurately coded on the MDS on 3/18/2025. Any residents found to not be accurately coded were modified. No residents sustained negative outcomes.<br>3. Education was provided to the Minimum Data Set (MDS)nursing staff on the importance of accurate coding of assessments and timely transmission of assessments. This was provided on 3/19/2025 by the Regional Director of Clinical Reimbursement (RDCR). | 3/25/25 |

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| F 641 | Continued From page 55<br>administering medications as ordered.<br><br>Resident #17's medical record revealed a level II PASARR determination date of 8/17/23.<br><br>The annual Minimum Data Set (MDS) assessment dated 7/6/24 indicated Resident #17 was not currently considered by the state level II PASARR process to have a serious mental illness.<br><br>On 2/21/25 at 2:08 PM in an interview with MDS Coordinator #1, he stated the 7/6/24 MDS for Resident #17 should have been coded as having a Level II PASARR determination.<br><br>2. Resident #67 was admitted to the facility on 5/29/21 with diagnoses that included anxiety disorder and depression.<br><br>Resident #67's care plan included a focus for the use of psychotropic medications and behaviors. Interventions included administering medications as ordered.<br><br>Resident #67's medical record revealed a level II PASARR determination date of 2/7/23.<br><br>The annual Minimum Data Set (MDS) assessment dated 4/5/24 indicated Resident #67 was not currently considered by the state level II PASARR process to have a serious mental illness.<br><br>On 2/21/25 at 2:08 PM in an interview with MDS Coordinator #1, he stated the 4/5/24 MDS for Resident #67 should have been coded as having a Level II PASARR determination. | F 641 | Any MDS nurse not receiving education will not be allowed to work until education is received.<br>New MDS nursing staff will receive education during the orientation process by the Regional Director of Clinical Reimbursement.<br>The Director of Nursing or designee will educate the practitioners on Centers for Medicare/Medicaid services (CMS) validation requirements for diagnosing Schizophrenia per the Diagnostic and Statistical Manual of Mental Disorders for diagnosing schizophrenia. This will be completed on 3/25/2025.<br>New providers will receive education by the Director of Nursing when they are onboarded to the facility.<br>The RDCR or designee will audit for death in the facility and verify the resident assessment is completed within the required timeframes per the RAI Manual 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x2.<br>The RDCR or designee will review residents with a new Level II PASARR determination letter and verify accurate MDS coding and care planning 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x2.<br>The RDCR or designee will review schizophrenia diagnosis for accurate coding 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x2.<br>The RDCR or designee will review 5x weekly x 4 weeks, then 3x weekly x 4 | |

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| F 641 | Continued From page 56<br>3. Resident #4 was admitted to the facility on 3/1/17 with diagnoses that included bipolar disorder.<br><br>Resident #4's care plan included a focus for behaviors such as refusal of care.<br><br>Resident #4's medical record revealed a level II PASARR determination date of 4/23/19.<br><br>The annual Minimum Data Set (MDS) assessment dated 12/10/24 indicated Resident #4 was not currently considered by the state level II PASARR process to have a serious mental illness.<br><br>On 2/21/25 at 2:08 PM in an interview with MDS Coordinator #1, he stated the 12/10/24 MDS for Resident #4 should have been coded as having a Level II PASARR determination.<br><br>4. Resident #14 was admitted to the facility on 2/7/2023 with diagnoses including osteoarthritis to both knees and partial intestinal obstruction.<br><br>Resident #14's care plan included a focus for pain related to arthritis and bowel (intestinal) blockage. Interventions included administering medications as ordered.<br><br>Physician orders dated 11/7/2024 for Resident #14 included Oxycodone (an opioid analgesic used to treat moderate to severe pain) 5 milligrams one tablet as needed for pain.<br><br>Resident #14's December 2024 Medication Administration Record MAR recorded Resident #14 received Oxycodone daily on the following dates: 12/1/2024 to 12/8/2024, 12/10/2024 to | F 641 | weeks, then weekly x 4 weeks, then monthly x2.<br>The MDS nurse or designee will review all new psychiatric practitioner notes prior to uploading them in the electronic health record, review new antipsychotic medication orders and the diagnosis list for the presence of Schizophrenia diagnosis 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x2.<br>4. Results will be reported by the MDS nurse to the quality assurance monthly meeting x 3<br>5. Date of completion : 3/25/2025 | |

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| F 641 | Continued From page 57 | F 641 | | |

12/14/2024, 12/16/2024 to 2/18/2024 and 12/20/2024 to 12/31/2024.

Resident #14's quarterly Minimum Data Set (MDS) assessment dated 12/20/2024 indicated Resident #14 was cognitively intact and was not coded for Resident #14 receiving opioid pain medication.

On 2/22/2025 at 8:30 p.m. in an interview with the MDS Coordinator #2, she stated Resident #14's December 2024 MAR recorded Resident #14 receiving opioid pain medication in the 7-day look back period for the MDS dated 12/20/2024, and Resident #14's MDS should have been coded for receiving opioid pain medication.

On 2/22/2025 at 8:42 p.m. in an interview with the Administrator, she stated Resident #14's MDS assessment should reflect Resident #14's information correctly.

5. Resident #41 was admitted to the facility on 1/24/2020 with diagnoses including major depressive disorder.

Physician's orders dated 12/11/2024 included Risperidone (an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder) 2 milligrams (mg) one tablet a day for anxiety, and Sertraline (a medication used for depression, panic disorders and social anxiety disorders) 50 mg one time a day for depression.

The psychiatric physician note dated 1/23/2025 recorded Resident #41 was receiving Risperidone 2 mg at night for management of schizophrenia. The psychiatric physician note also reported there was no increase in symptoms of anxiety or

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| F 641 | Continued From page 58 | F 641 | | |

depression and staff reported no behavioral concerns suggesting the current medication was effective in managing Resident #41's schizophrenia.

Resident #41's February Medication Administration Record recorded Resident #41 received Risperidone 2mg daily from 2/1/2025 to 2/22/2025.

The quarterly Minimum Data Set (MDS) assessment dated 2/11/2025 indicated Resident #41 was moderately cognitively impaired and had displayed no behaviors in the 7-day look back period. Resident #41's MDS was coded for receiving antipsychotic medication on a daily basis and was not coded for schizophrenia.

On 2/22/2025 at 8:27 p.m. in an interview with MDS Coordinator #2, she stated Resident #41's MDS dated 2/11/2025 was not coded for schizophrenia due to not finding supportive evidence to validate the diagnosis of schizophrenia. She stated the psychiatric physician note was not enough evidence to support coding Resident #4's MDS for schizophrenia.

On 2/22/2025 at 8:41 p.m. in an interview with Corporate Nurse Consultant #1, she stated coding Resident #41 as Schizophrenia triggers an audit and Resident #41's medical record may need to include more than the psychiatric physician note to code the MDS for schizophrenia.

6. Resident #10 was admitted to the facility on 1/13/25 with diagnoses including cerebral infarction (stroke), peripheral artery disease, and

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| F 641 | Continued From page 59<br>coronary artery disease.<br><br>Resident #10's physician orders noted orders dated 1/14/25 for Plavix (an antiplatelet) 75 milligrams (mg) one tablet daily and Aspirin Chewable (an antiplatelet) 81mg one tablet daily. There were no orders for an anticoagulant.<br><br>Resident #10's admission Minimum Data Set (MDS) assessment dated 1/20/25 indicated he was severely cognitively impaired. The MDS indicated he was taking anticoagulants (prevent or reduce blood clotting) and antiplatelets (prevents platelets from clumping together and forming blood clots).<br><br>In an interview with the MDS Coordinator on 2/22/25 at 4:13 PM, she said the MDS was miscoded and Resident #10 was not on any anticoagulants.<br><br>In an interview with the Administrator on 2/22/25 at 6:34 PM, she said the MDS assessments were expected to be accurate. | F 641 | | |
| F 660 SS=G | Discharge Planning Process<br>CFR(s): 483.21(c)(1)(i)-(ix)<br><br>§483.21(c)(1) Discharge Planning Process<br>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-<br>(i) Ensure that the discharge needs of each | F 660 | | 3/25/25 |

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| F 660 | Continued From page 60 | F 660 | | |

resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or

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| F 660 | Continued From page 61<br>LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.<br>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff, family member, and home health agency staff interviews, the facility failed to implement an effective discharge planning process and to ensure a resident had home health services arranged prior to discharge for 1 of 3 resident reviewed for discharge (Resident #181).<br><br>The findings included:<br><br>Resident #181 was admitted to the facility on 8/19/24 with diagnoses that included diabetes mellitus and malnutrition.<br><br>Resident #181's admission Minimum Data Set | F 660 | F660<br>1. Resident # 181 received home health services after being discharged to the community by primary care provider.<br>2. An audit was conducted by the social services team of the last 30 days of discharges to the community to ensure that all home health services were arranged. This audit was completed 3/18/2025.<br>3. Education was provided to the social services team by the administrator or designee on the discharge planning process including ensuring home health is set up for all services. This education was | |

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| F 660 | Continued From page 62<br>assessment dated 8/25/24 coded him as being cognitively intact, requiring limited assistance for most activities of daily living, required a feeding tube and having the expectation to be discharged to the community.<br><br>Review of Resident #181's record revealed he was discharged home on 8/29/24.<br><br>A discharge note dated 8/29/24 written by the physician assistant revealed Resident #181 had tolerated meals with 50% of intake and the g-tube was clamped off. The g-tube was placed during his hospitalization prior to his admission to the facility.<br><br>Record review revealed there was no mention of discharge planning for Resident #181 from the time of admission (8/19/24) through the date of his discharge home (8/29/24).<br><br>Resident #181 was not care-planned for discharge.<br><br>Review of Resident #181's discharge summary dated 8/29/24 revealed home health services were arranged with a local home health agency for nurse aide services, physical and occupational therapy. The discharge summary provided the local home health agency name and contact number for reference. The discharge summary had no instructions for use of or care of the feeding tube. The discharge instructions stated he received a mechanically altered diabetic diet with nectar thickened liquids.<br><br>An interview was conducted with Resident #181's family member on 2/17/25 at 12:25 PM who reported Resident #181 was not referred to home | F 660 | completed on 3/19/2025.<br>Any social services team member will not be allowed to work until education is received.<br>Any new social services team member will be educated by the administrator during the orientation process.<br>The Administrator or designee will audit planned discharges to ensure home health services have been ordered 5 x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2<br>4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br>5. Date of completion: 3/25/2025 | |

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| F 660 | Continued From page 63 | F 660 | | |

health prior to discharge from the facility. She reported she coordinated with Resident #181's insurance and primary care provider to get his home health arranged. The family member stated Resident #181's insurance coverage had ended which led to his discharge on 08/29/24. Resident #181's family member stated care for him was difficult because he came home with a feeding tube, however they did the best they could to care for Resident #181 before home health was involved. She reported that when the home health agency came to assess him 9/12/24 he was transferred to the local hospital. He was kept overnight for observation. Resident #181 returned home after his hospitalization and the family was able to care for his feeding tube with the assistance of home health.

A review of hospital records indicated on 9/12/2024 Resident #181 was dysphagic (difficulty in swallowing), his blood glucose was 327 (normal blood sugar levels are considered to be between 70 milligrams per deciliter [mg/dL] to 100mg/dL), and he had not been using the g-tube that was inserted on 8/13/2024 because the patient did not know how to use the g-tube and home health did not start until 9/12/2024. The hospital records stated Resident #181 reported he was never given instructions on how to use the g-tube at home. The hospital records indicated Resident #181 had lost 19.2 pounds since the hospital discharge on 8/19/2024. The hospital records stated Resident #181 reported the g-tube was for supplemental feedings and was not used while at the nursing home. Resident #181 reported only receiving oral intake at the nursing home and was not provided g-tube supplemental feeding. Resident #181 reported attempting oral liquids and becoming weaker since discharge

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from the nursing home. The hospital record listed Resident #181 on sliding scale insulin and insulin before meals and at night. Resident #181 was diagnosed with a urinary tract infection, acute kidney failure and hyperglycemia (a medical condition in which the body's blood glucose level is higher than normal) and admitted to the hospital. During hospitalization, he was seen by a Speech Language Pathologist who recommended continued use of the g-tube as primary means of nutrition, hydration, and medication administration. The discharge summary dated 9/18/2024 included the diagnoses of severe protein-calorie malnutrition, failure to thrive, chronic dysphagia, and diabetes mellitus. The outpatient follow up items included bolus tube feed regimen and insulin regimen. He was discharged with home health services.

During an interview with a staff member from the same local home health agency listed on Resident #181's discharge summary on 2/22/25 at 3:25 PM the staff member stated Resident #181 was referred to their office by his primary care provider on 9/11/24. She reported there was no referral from the skilled nursing facility.

On 2/22/25 at 3:36 PM an interview was conducted with the facility Social Worker who stated she was not employed at the facility at the time of Resident #181's discharge. She stated she had checked the social work office and could find no mention of his stay at the facility. The facility Social Worker stated the process that should have been followed was Resident #181's home health services should have been arranged prior to discharge. She stated she documented all discharge coordination in progress notes and on the discharge summary.

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| F 660 | Continued From page 65<br><br>Attempts to contact the former facility Social Worker were unsuccessful.<br><br>Calls to the former Administrator were not returned.<br><br>An interview was conducted with the Administrator who stated the Social Worker was responsible for ensuring services were in place for residents at the time of discharge. She reported neither she nor the current Social Worker were employed with the facility at the time of Resident #181's discharge. | F 660 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and resident representative and staff interviews, the facility failed to provide incontinent care to a resident that was dependent on nursing staff assistance for activities of daily living (ADL) for 1 of 3 residents reviewed for ADL (Resident #33).<br><br>Findings included:<br><br>Resident #33 was admitted to the facility on 4/20/2022 with diagnoses including Alzheimer's disease and aphasia (inability to speak).<br><br>Resident #33's care plan dated 1/10/2025 indicated Resident #33 was incontinent of urine | F 677 | F677<br>1. Resident #33 received incontinence care.<br>2. Current residents with a BIMS of 13-15 will be interviewed by the leadership team to ensure incontinence care is occurring. This will be completed by 3/19/2025.<br>3. Education to current nursing staff including current agency staff on timeliness of incontinence care. Education will be provided by the Director of Nursing or designee. Education initiated on 3/19/2025.<br>Any nursing staff not receiving education | 3/25/25 |

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| F 677 | Continued From page 66<br>and stool. Interventions included one person assistance with toileting and providing toileting hygiene when changing adult briefs.<br><br>The significant change Minimum Data Set (MDS) assessment dated 1/22/2025 indicated Resident #33 was severely cognitively impaired, incontinent of urine and stool and was dependent on nursing staff to provide all activities of daily living.<br><br>On 2/17/2025 at 10:47 am in a phone interview with Resident #33's Representative, she voiced a concern that Resident #33 was found soaked with urine when NA # 9 reported to work at 3:00pm on 2/14/2025. Resident #33's representative stated when she visited after 5:00pm on 2/14/2025, NA #9 informed her Resident #33 and the bed linens were soaked with urine when she came on shift that day.<br><br>On 2/21/2025 at 7:37 pm in a phone interview with Nurse Aide (NA) #9, she explained the on-coming nurse aide and off-going nurse aide were to check the residents at the end of a shift and on 2/14/2025, she did not check the residents with NA #12. She stated she reported to work at 3:00 pm on 2/14/2025, put away her personal belongings and promptly began checking the dependent residents on her assignment. She stated Resident #33 was observed with the adult brief, the two piece pajama set Resident #33 was wearing, the draw sheet and the fitted sheet underneath Resident #33, the top sheet and the bed covering wet with urine. She stated NA #12 assisted her in changing Resident #33 and she did not ask NA #12 why Resident #33's adult brief had not been changed. NA #9 stated Resident #33's adult briefs were usually not very wet when changed | F 677 | will not be allowed to work until education is received. Agency staff will receive the education prior to the start of their shift. New nursing employees will receive education during the orientation process by the Director of Nursing or designee.<br>Director of nursing or designee will interview 10 residents with BIMS 13-15 weekly x 4, then 5 residents weekly x 4, then 3 residents weekly x 4, then 5 residents monthly x 2.<br>The Director of Nursing or designee will audit 10 random residents with BIMS less than 13 for timely incontinence care. This will be done weekly x 12 weeks, then monthly x 2<br>4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br><br>5. Date of completion is 3/25/2025 | |

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| F 677 | Continued From page 67<br>every two hours.<br><br>On 2/22/2025 at 9:04 pm in a phone interview with NA #12, she stated she worked a 7:00 am to 3:00 pm shift and a 3:00pm to 11:00 pm shift on 2/14/2025. She stated her assignment consisted of rooms 13 rooms for the 7:00 am to 3:00 pm shift that included four residents to assist with eating during that shift. She stated she was able to complete personal and incontinent care for all the assigned residents and Resident #33 was included in her assignment on 2/14/2025 during the 7:00am to 3:00pm shift. She recalled changing Resident #33 that morning, during her bath before lunch and after assisting Resident #33 with lunch at approximately 12:30 pm. She stated she assisted NA #9 providing incontinent care after 3:00pm and admitted Resident #33's bed linens were wet. She explained due to Resident #33's adult brief positioned sideways the urine had wet the bed linens and Resident #33's pajamas rather than the adult brief.<br><br>On 2/22/2025 at 3:48 pm in an interview with Interim Director of Nursing, she stated she was not aware NA #9 had observed Resident #33's clothing and bed linens wet with urine upon reporting to work at 3:00 pm. She stated nursing staff were to check residents dependent on assistance with activities of daily living every two hours and/or as needed. | F 677 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | F 689 | | 3/25/25 |

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| F 689 | Continued From page 68<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to equip 2 of 2 designated resident smoking areas with fire preventative equipment (Smoking Area #1 and Smoking Area #2) and to complete a quarterly smoking assessments for 1 of 1 resident reviewed for smoking (Resident #37).<br><br>Findings included:<br><br>1. On 2/16/2025 at 12:35 pm, one resident was observed smoking in Smoking Area #1, the designated shelter covered smoking area outside the activities recreation room. Smoking Area #1 was observed with a fire extinguisher, two small 4 inch diameter ash trays and a small beige plastic trash can. There was no smoking aprons, fire blanket or self-closing metal containers to empty ashtrays observed in Smoking Area #1.<br><br>On 2/16/2025 at 3:14 pm, a new non-sheltered designated smoking area, Smoking Area #2, was observed with three vinyl chairs, two plastic foot pedal trash cans, a fire extinguisher, three hanging fire aprons and one metal standing ash tray. There was no smoking blanket or metal containers with self-closing covers into which ashtrays would be emptied in Smoking Area #2.<br><br>On 2/16/2025 at 4:38 pm in an interview with the Administrator, she stated the facility was in the process of moving the designated smoking area from Smoking Area #1 to Smoking Area #2 due to | F 689 | F689<br>1. Fire retardant blanket was placed in the smoking area on 3/19/2025. Ashtrays were added to the smoking area on 3/19/2025.<br>2. Current residents will have a safe smoking tool completed by the nursing leadership team completed by 3/25/2025.<br>3. The Administrator provided education to the maintenance department on the equipment needs of the smoking area. This was completed on 3/19/2025.<br>Director of Nursing or designee will educate licensed nursing staff including agency licensed nurses on the need to complete quarterly safe smoking tool.<br>Maintenance department will not be able to work until education is received.<br>New maintenance employees will receive education during the orientation process by the administrator.<br>Any licensed nurse will not be allowed to work until education is received. Agency staff will receive education prior to the start of their shift by the Director of Nursing or designee.<br>The director of nursing or designee will audit 10 residents to ensure they have a quarterly safe smoking assessment completed weekly x 4, then 5 residents weekly x 4, then 3 residents weekly x 4, then 5 residents monthly x 2. Any new licensed nurses will receive education | |

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| F 689 | Continued From page 69<br>residents voicing concerns of smoke getting into the activities recreation room.<br><br>On 2/18/2025 at 2:59 pm in an observation of Smoking Area #2, there was one cigarette butt observed in the plastic foot pedal trash can. Two residents were observed smoking in the Smoking Area #2.<br><br>On 2/22/2025 at 12:59 pm in an observation of Smoking Area #2, there was a plastic bag filled with trash and several cigarette butts observed in the plastic bag in the plastic trash can positioned to the right of the door when entering Smoking Area #2.<br><br>On 2/22/2025 at 1:42 pm in an interview with the Administrator, she explained all of the smokers in the facility were unsupervised smokers and stated either Smoking Area #1 (used in inclement weather only) or Smoke Area #2 were used daily by the smokers. She stated that due to the limited amount of equipment observed in the designated smoking areas, all equipment observed in Smoking Area #2 was to be moved to Smoking Area #1 when it was used for inclement weather. She stated she needed to order fire preventative equipment. including metal containers for ashes, for Smoking Area #1 and Smoking Area #2. She stated the facility did not have fire blankets for Smoking Area #1 and Smoking Area #2 and stated the smoking aprons could be used as a fire blanket.<br><br>2. Resident #37 was admitted to the facility on 3/1/2024 with diagnoses including stroke.<br><br>Resident #37's care plan included a focus for smoking dated 8/14/2024, and interventions | F 689 | during the orientation process by the Director of Nursing or designee<br>The Maintenance director of designee will audit the smoking area for equipment 3x weekly x 4 weeks weekly x 4 weeks and monthly x 1 to ensure equipment is in place.<br>4. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br><br>5. Date of completion 3/25/2025 | |

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included performing smoking assessments as needed.

A smoking assessment dated 9/6/2024 recorded Resident #37 had dexterity problems and indicated Resident #37 could smoke unsupervised. This was Resident #37's most recent smoking assessment.

The quarterly Minimum Data Set (MDS) assessment dated 11/18/2024 indicated Resident #37 was moderately cognitively impaired and had upper and lower extremity limited range of motion on one side of the body.

On 2/16/2025, a list of independent unsupervised smokers was provided by the Administrator and Resident #37 was listed on the facility's smoking list as an independent unsupervised smoker.

On 2/18/2025 at 2:59 pm, Resident #37 was observed smoking in the new non-sheltered designated smoking area accompanied by family members. Resident #37 was observed holding his cigar in the right hand with controlled movements to and from the lips while smoking. Resident #37 was observed positioned approximately four feet from the metal standup ashtray in a wheelchair and dropping ashes onto the concrete. There were no staff members observed in the smoking area.

On 2/22/2025 at 3:11 pm in an interview with the Interim DON, she explained smoking assessments were triggered to complete quarterly after the MDS assessment, on admission and re-admissions to the facility. She stated nurses were responsible for conducting smoking assessments, and Resident #37 should

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| F 689 | Continued From page 71<br>have had a smoking assessment conducted since the last documented smoking assessment dated 9/6/2024 in December 2024. She stated due to starting employment with the facility in January 2025, she didn't know why Resident #37 did not have a smoking assessment completed in December 2024 and added Resident #37 had triggered for a smoking assessment on 2/22/2025. | F 689 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff and Physician interviews, the facility failed to ensure effective pain management for a resident with an unwitnessed documented fall on 1/27/25 and failed to provide pain management when assessed by the floor nurse during neurological assessments (an assessment done by the nurse to evaluate for potential brain injuries by checking mental status, level of consciousness, motor function, sensation, coordination, and reflexes) and used a numerical pain scale (a scale that uses numbers from 0 to 10 to measure pain with 0 meaning no pain and 10 meaning the worst pain) and having pain verbalized a 3 out of 10 for three (3) assessments and 6 out of 10 for four (4) assessments for 1 of 1 resident reviewed for pain management (Resident #25). | F 697 | F697<br>1. Resident # 25 is receiving adequate pain control.<br>2. An audit was completed by the Director of Nursing and designee to review the last 7 days of nursing notes to ensure any noted changes in residents□ pain condition were noted and the physician had been notified. This was completed by the Director of nursing on 03/25/2025. The audit included a review of nursing notes and 24-hour shift to shift reports.<br>3. Education initiated by the Director of Nursing and designee to current licensed nurses staff including agency staff regarding notification of provider when any noted changes in resident□s pain is | 3/25/25 |

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| F 697 | Continued From page 72<br>The findings included:<br><br>Resident #25 was admitted to the facility on 9/24/24 with diagnoses which included transient ischemic attack (TIA), cerebral infarction without deficits, and type 2 diabetes mellitus.<br><br>Resident #25's care plan dated 9/24/24 revealed a focus for fall risk related to the need for assistance with transfers. Interventions included: offer to place resident in bed after lunch, place common items within reach of the resident, and remind resident to use their call light for assistance with activities of daily living (ADL).<br><br>Review of Resident #25's quarterly Minimum Data Set (MDS) dated 12/31/24 revealed she was cognitively intact. Resident #25 required staff assistance with activities of daily living (ADL).<br><br>A progress note dated 1/27/25 revealed Resident #25 was found on the floor lying on her back between her nightstand and her wheelchair and her left knee was bent. Resident #25 denied hitting her head but complained her left knee hurt "pretty bad". The physician and resident representative (RP) were notified. Resident #25 was noted to have regular socks on both of her feet. The physician ordered an x-ray of the left knee.<br><br>Review of the neurological checklist dated 1/27/25 at 2:00 pm and completed by Nurse #3 revealed the following:<br>- Q (every)15 minutes (Nurse checks resident every 15 minutes) at 2:00 pm<br>BP: 124/90, pulse- 83, respirations- 18, alert and oriented x (times) 4<br>(Person-Place-Time-Situation), verbal | F 697 | observed. Education initiated on 3/19/2025.<br>Any licensed nurse will not be able to work until education received.<br>Agency licensed nurses will receive education prior to the start of their shift by a member of nursing leadership team.<br>Any new licensed nurses will receive this education in orientation.<br>The Director of Nursing or designee will audit the nursing progress notes for any changes in pain and notification of provider 5 x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2<br>4. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br><br>5. Date of completion: 3/25/2025 | |

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expressions of pain marked- yes, and numerical ain scale: 6.

- Q15 at 2:15 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 6.

- Q15 at 2:30 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 6

- Q15 at 2:45 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 6.

- Q30 minutes (Nurse checks resident every 30 minutes) at 3:15 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 3.

- Q30 at 3:45 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 3.

- Q30 at 4:15 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 3.

- Q30 at 4:45 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 3.

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- Q 1 hour (Nurse checks resident every hour) at 5:45 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 3.

- Q 1 hour at 6:45 pm
Alert and Oriented x 3 (Person-Place-Time), verbal expressions of pain marked- yes, and numerical pain scale: 3.

- Q 1 hour at 7:45 pm
Alert and Oriented x 3 (Person-Place-Time) and verbal expressions of pain marked: No.

- Q 1 hour #4 at 8:45 pm
Alert and Oriented x 3 (Person-Place-Time) and verbal expressions of pain marked: No.

Review of a 72-hour post fall documentation note dated 1/28/25 at 5:45 pm and completed by Nurse #3 revealed Resident #25 reported pain in her left knee. Nurse #3 obtained an order for x-ray of left knee. There was no documentation of pain medication given to Resident #25 noted.

A physician's order was obtained on 1/28/25 for an x-ray for Resident #25's left knee and completed by the facility's mobile x-ray unit.

Review of Resident #25's x-ray results of her left knee dated 1/29/25 documented an acute hairline fracture of the left knee with mild swelling noted.

Review of a progress note dated 1/29/25 at 9:09 am and completed by the Interim Director of Nursing (DON) revealed the Interdisciplinary Team (IDT) met and discussed Resident #25's fall on 1/27/25. The results of the x-rays

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completed were discussed and Resident #25 was sent to the hospital for evaluation.

Review of Resident #25's physician orders revealed no order for pain medication prior to being sent to the hospital for evaluation or after returning to the facility from the hospital on 1/29/25.

Review of Resident #25's January Medication Administration Record (MAR) revealed no pain medication had been given.

Review of physician's note dated 1/29/25 revealed he saw Resident #25 for a follow-up visit after an x-ray report noted a hairline fracture of the left knee. Her vital signs were within normal limits (WNL). Physical exam noted Resident #25 was awake and alert with decreased mobility and left shoulder painful to touch. Resident #25 was sent to emergency department (ED) for further evaluation.

Review of hospital discharge summary dated 1/29/25 revealed Resident #25 presented to the emergency department (ED) for evaluation of a fall on 1/27/95. A Computed Tomography (CT) scan of the head (which is a procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of the brain) was completed with no evidence of intracranial hemorrhage. A CT scan of the cervical spine was completed with no evidence of fracture. An x-ray of the left femur (bone of the thigh) was completed with no evidence of a fracture. An x-ray of the pelvis (the bones between the lower abdomen and upper thighs that connect the spine to the legs) was completed with no evidence of a fracture. An x-ray of the left tibia fibula (two long

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bones located in the lower leg) was completed with no evidence of a fracture, but moderate swelling was noted. Resident #25 was discharged from the hospital on 1/29/25 with no new referral or medication orders.

In a phone interview with Nurse #3 on 2/20/25 at 2:01 pm, she stated she was the nurse when Resident #25 was found on the floor. Nurse #3 did not remember the nurse aide who reported this to her. Nurse #3 further stated she did neurological assessments on Resident #25 which documented pain on a scale from 3 to 6 from Resident #25. Nurse #3 explained the facility has a standing order for pain. The facility's standing order for pain was Acetaminophen 650 milligrams (mg) every 4 hours as needed for mild pain for 72 hours and to notify physician after 72 hours if pain persisted. When Nurse #3 was asked did she give Resident #25 any Acetaminophen, she replied no. Nurse #3 indicated she did not notify the physician of Resident #25's pain but should have notified the physician of Resident #25's pain.

During a telephone interview on 2/20/25 with Physician # 1, he stated he was aware of Resident #25's fall on 1/27/25. He further stated he ordered x-rays of her left knee. Physician #1 indicated he was not aware Resident #25 had any complaints of pain. The Physician indicated the facility's standing orders for Acetaminophen should have been administered.

During an interview on 2/22/25 at 10:39 am with Resident #25, she stated she had a fall in January and hurt her left knee. Resident #25 further stated she was told she fractured her knee, but the staff told her there was no fracture

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after returning from the hospital. Resident #25 recalled going to the hospital for her knee pain. Resident #25 stated she did not receive any medication for pain at the facility prior to being sent to the hospital for evaluation or after returning to the facility from the hospital on 1/29/25. She explained she still had mild knee pain, and it hurts more when the nursing staff roll her on her side to perform incontinent care. When asked did she inform the nursing staff of her knee pain, she replied yes but did not state if she asked for pain medication.

Nurse Aide (NA) #4 was interviewed on 2/22/25 at 3:06 pm. NA #4 stated she remembered the incident on 1/27/25 but she was not assigned to Resident #25 on that day. NA #4 stated she worked with Resident #25 after her fall on 1/27/25 and she complained of leg pain with incontinent care after the incident but cannot recall the exact dates. NA #4 further stated she reported complaints of pain to the floor nurse.

In an interview with the Interim Director of Nursing (DON) on 2/22/25 at 5:00 pm, she stated Resident #25 was sent to the hospital for evaluation on 1/29/25. The Interim DON's expectations were that the nursing staff monitored the residents for pain every shift and as needed (PRN) and inform the Physician for pain management if indicated.

During an interview on 2/22/25 at 5:00 pm with the Administrator, she stated she was aware Resident #25's fall on 1/27/25. She further stated she was unaware of Resident #25's complaints of pain but expected the nursing staff to monitor the residents for pain during their shifts and as needed (PRN) and inform the Physician for pain

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| F 697 | Continued From page 78<br>management if indicated. | F 697 | | |
| F 726 SS=J | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation, and staff and Medical Director interviews, the facility failed | F 726 | F726<br>1. The facility failed to ensure Nurse #1 | 3/25/25 |

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| F 726 | Continued From page 79<br>to ensure nursing staff were competent in following manufacturer's guidelines for cleaning and disinfecting a shared glucometer when Nurse #1 was observed not disinfecting a shared glucometer (Resident #35). Also, Medication Aide #1 (an agency staff member) failed to clean and disinfect an individually assigned glucometer using the approved disinfectant wipes according to manufacturer's recommendations for Resident #32 who was observed having a blood glucose level checked. This occurred for 2 of 7 nursing staff members (Nurse #1 and Medication Aide #1) reviewed for competency.<br><br>Immediate jeopardy began on 2/17/25 when Nurse #1 failed to demonstrate competency through her failure to disinfect a shared glucometer per manufacturer's instructions. Immediate jeopardy was removed on 2/19/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) for finding #2 and for the facility to complete agency and employee staff training with monitoring to ensure appropriate interventions are put into place.<br><br>The findings included:<br><br>1. The skills validation record for Nurse #1 dated 5/7/2024 included the use of equipment that included glucometers. The former Assistant Director of Nursing signed the validation form on 5/7/2024.<br><br>An educational in-service roster dated 9/11/2024 and 9/12/2024 on cleaning glucometers between | F 726 | was trained and competent in following manufacturer□s guidelines for cleaning and disinfecting a shared glucometer and on knowing how to distinguish an individually assigned resident glucometer from a shared glucometer.<br>2. Current residents who require finger stick blood sugars received their own individual glucometers and they were labeled and placed in an individual container. The was completed by the Director of Nursing and the Assistant Director of Nursing on 2/18/2025.<br>3. Education was started by the Director of Nursing on 2/18/2025 to current licensed nursing staff, including agency staff, on proper procedure for cleaning glucometers and for proper storage of glucometers. Employees not receiving this education will not be allowed to work until the education is received. The Director of Nursing will track the education to ensure that current staff have received.<br>Education includes each resident who receives a finger stick blood sugar will have an individual glucometer that is labeled with their name and stored in an individual container inside the med cart. Education also includes the proper cleaning technique as recommended by the manufacturer guidelines. The cleaning product will be kept on each medication cart. The Director of Nursing or charge nurse will check the med carts daily to ensure that the cleaning product is present on each med cart. The Director of Nursing educated the charge nurses on 2/18/2025. The Director of Nursing was educated on this process by the | |

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| F 726 | Continued From page 80<br>patients every time for infection control practices stated to allow the glucometer to air dry 2 minutes after wiping with purple wipes and place on a clean surface to dry. Nurse #1's signature was not included on the roster to indicate she had received the education.<br><br>On 2/17/2025 at 5:50 am in preparation to check Resident #35's blood glucose, Nurse #1 was observed searching for Resident #35's glucometer. Nurse #1 stated each resident had their individually assigned glucometer to check blood glucose levels. Nurse #1 was observed opening the top drawer of the 100-hall medication cart flipping three glucometer pouches labeled with Resident #66's, Resident #33's and Resident # 93's name and room number upward toward Nurse #1. Nurse #1 was observed locking the 100-hall medication cart and walking to the 200-hall medication cart before returning to the 100-hall medication cart and reopening the top drawer. Nurse #1 reflipped Resident #66's, Resident #33's and Resident # 93's labeled glucometer pouches upward toward her and picked up Resident #33's glucometer pouch. There was an unlabeled glucometer not in a labeled glucometer pouch observed underneath Resident #33's glucometer pouch. Nurse #1 stated the unlabeled glucometer was Resident #35's glucometer and was observed not disinfecting the glucometer before performing a blood glucose test on Resident #35 on 2/17/2025 at 5:56 am. Nurse #1 was observed returning the used unlabeled glucometer to the top drawer of the 100-hall medication cart without disinfecting the glucometer.<br><br>On 2/17/2025 at 6:00 am in an interview with Nurse #1, she stated Resident #35 did not have a | F 726 | Administrator on 2/18/2025.<br>Current Licensed Nurses will complete a skills return demonstration on glucometer cleaning and storage. This will be completed by the Director of Nursing. Any licensed nurse will not be allowed to work until return demonstration has been completed. The Director of Nursing will track the education to ensure that current staff have received.<br>The Director of Nursing or charge nurse is responsible for ensuring new admissions who require finger stick blood sugars are provided with their own individual glucometer that is labeled with their name and stored in an individual container. The Director of Nursing was educated on this process by the Administrator on 2/18/2025. The charge nurses are educated on this process by the Director of Nursing on 02/18/2025.<br>New licensed nurses will receive this education and verify competencies during the orientation process by the Director of Nursing or charge nurse. Agency nurses will receive this education and competencies prior to the start of their shift. The charge nurses were educated on this responsibility by the Director of Nursing on 02/18/2025. The Director of Nursing will assign the charge nurse to complete this task when needed.<br>Director of Nursing or designee will audit 10 resident glucometer checks weekly x 4 weeks, then 5 x 4 weeks, then 3 weekly x 4 weeks. then 3 monthly x 2.<br>The Director of Nursing or designee will audit the med carts for cleaning solution 3x weekly x 4 weeks, then 2 weekly x 4 | |

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| F 726 | Continued From page 81<br>labeled glucometer pouch and the reason she did not disinfect the glucometer before performing the blood glucose was because the staff member who used the glucometer before she used it should have disinfected the glucometer. Nurse #1 stated she did not think about disinfecting the glucometer after performing the blood glucose test. Nurse #1 was observed removing an alcohol pad from the top drawer of the 100-hall medication cart and wiping the unlabeled glucometer without an resident identified glucometer pouch with the alcohol pad and returning the unlabeled glucometer to the top drawer of the 100-hall medication cart. She stated she always disinfected glucometers with alcohol pads and Resident #35 was the only blood glucose monitoring she had to perform.<br><br>In an interview with Nurse #2 on 2/18/2025 at 10:08 am, she identified the unlabeled / unidentified glucometer not stored in a pouch with a resident's name and room number as a shared glucometer. She stated the Resident #35 and Resident #31 who resided on the 100 hall did not have individually assigned glucometers and shared the unlabeled / unidentified glucometer. She also stated a disinfectant wipe was used to clean glucometers after each use on a resident.<br><br>On 2/18/2025 at 10:42 am in a follow up phone interview with Nurse #1, she stated she thought the unlabeled glucometer that was not in a pouch labeled with a resident's name and room number on the 100-hall medication cart was Resident #35's glucometer on 2/17/2025 when performing the blood glucose monitoring. She stated Resident #31 also received blood glucose monitoring and did not have an individually assigned glucometer, and she had forgotten | F 726 | weeks, then weekly x 4 weeks, then monthly x 2<br>The Director of Nursing will audit the residents requiring glucometers to ensure glucometers present 3x weekly x 4 weeks, then 2x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2<br>4. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br>5. Date of completion: 3/25/2025 | |

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Resident #35 and Resident #31 shared the unlabeled glucometer not in a labeled pouch. Nurse #1 stated she was trained on how to use and disinfect a glucometer with employment orientation and was unable to recall the instructions on how to use the disinfectant wipes at the facility. She reported there were no disinfectant wipes on the 100-hall medication cart to clean the glucometer on the morning of 2/17/2025.

On 2/17/2025 at 6:50 am in an interview with the Director of Nursing (DON), she stated the facility did not have a glucometer for every resident receiving blood glucose monitoring, and some of the glucometers on the medication carts were shared between residents. The DON stated Nurse #1 was to clean the glucometer that was shared between residents with the facility's EPA-disinfected wipes and allow the glucometer to dry for two minutes before storing in the resident's labeled glucometer pouch. The DON stated since starting at the facility five weeks ago, she had seen documentation that the nursing staff had received an educational in-services on cleaning and disinfecting glucometers.

There was no documentation provided by the facility that recorded educational in-services were conducted on cleaning and disinfecting glucometers since 9/12/2024.

The facility's Administrator was informed of the immediate jeopardy (IJ) on 2/18/2025 at 2:00 pm.

The facility provided the following plan for IJ removal:

Identify those recipients who have suffered, or

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are likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to ensure Nurse #1 was trained and competent in following manufacturer's guidelines for cleaning and disinfecting a shared glucometer and on knowing how to distinguish an individually assigned resident glucometer from a shared glucometer.

Nurse #1 failed to ensure an unlabeled / unidentified glucometer that was shared between Resident #35 and Resident #31 on the 100-hall medication cart was cleaned and disinfected prior to and after use. (Resident #35) Nurse #1 thought the glucometer was individually assigned to Resident #35 and had forgotten that the unlabeled / unidentified glucometer was also used on Resident #31.

Nurse #1 indicated the glucometer used for Resident #35 was individually assigned. She stated she did not think about cleaning and disinfecting the unlabeled / unidentified glucometer after performing Resident #35's blood glucose and stated she always cleaned residents' glucometer with alcohol wipes. The Director of Nursing stated the facility did not have a glucometer for every resident receiving blood glucose monitoring and some of the glucometers on the medication carts were shared between residents. The DON stated glucometers were to be cleansed with an approved disinfectant.

Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an EPA-registered disinfectant in accordance with the

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manufacturer's instructions to disinfect a shared glucometer potentially exposes residents to the spread of blood borne infections. Six residents within the facility were identified as having a diagnosis which included one or more blood borne pathogens.

Nurse # 1 was removed from the schedule on 2/17/2025 and will be educated with a competency prior to returning to work. This will be completed by the Director of Nursing.

Current residents that receive finger stick blood sugar checks are at risk. Forty residents require FSBS and all forty have been provided their individual glucometer. The Assistant Director of Nursing completed an audit on 2/18/2025.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:
Current residents who require finger stick blood sugars received their own individual glucometers and they were labeled and placed in an individual container. The was completed by the Director of Nursing and the Assistant Director of Nursing on 2/18/2025.
Education was started by the Director of Nursing on 2/18/2025 to current licensed nursing staff, including agency staff, on proper procedure for cleaning glucometers and for proper storage of glucometers. Employees not receiving this education will not be allowed to work until the education is received. The Director of Nursing will track the education to ensure that current staff have received.

Education includes each resident who receives a

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finger stick blood sugar will have an individual glucometer that is labeled with their name and stored in an individual container inside the med cart. Education also includes the proper cleaning technique as recommended by the manufacturer guidelines. The cleaning product will be kept on each medication cart. The Director of Nursing or charge nurse will check the med carts daily to ensure that the cleaning product is present on each med cart. The Director of Nursing educated the charge nurses on 2/18/2025. The Director of Nursing was educated on this process by the Administrator on 2/18/2025.

Current Licensed Nurses will complete a skills return demonstration on glucometer cleaning and storage. This will be completed by the Director of Nursing. Any licensed nurse will not be allowed to work until return demonstration has been completed. The Director of Nursing will track the education to ensure that current staff have received.

The Director of Nursing or charge nurse is responsible for ensuring new admissions who require finger stick blood sugars are provided with their own individual glucometer that is labeled with their name and stored in an individual container. The Director of Nursing was educated on this process by the Administrator on 2/18/2025. The charge nurses are educated on this process by the Director of Nursing on 02/18/2025.

New licensed nurses will receive this education and verify competencies during the orientation process by the Director of Nursing or charge nurse. Agency nurses will receive this education and competencies prior to the start of their shift.

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The charge nurses were educated on this responsibility by the Director of Nursing on 02/18/2025. The Director of Nursing will assign the charge nurse to complete this task when needed.

Immediate Jeopardy removal date 2/19/2025.

The facility's credible allegation of immediate jeopardy removal was validated on 2/22/25.
A phone interview with the medical director on 2/18/2025 validated the facility had notified the physician of the deficient practice and the facility was implementing new practices that included an individual glucometer per resident and educating the nursing staff on how to disinfect the glucometer after use on a resident. Observation of the 43 residents' (40 plus 3 admissions since 2/18/2025) individually assigned glucometers who currently resided in the facility on 2/22/2025 validated each resident receiving blood glucose monitoring had an individually assigned glucometer in a glucometer pouch labeled with their name and room number. Medication aides reported during interviews that blood glucose monitoring was performed by licensed nursing staff in the facility and medications aides did not conduct blood glucose monitoring in the facility. Interviews with licensed nursing staff on each hallway and on all shifts validated in-service training was conducted in regard to the use of individually assigned glucometers for resident blood glucose monitoring and the infection control practices for the disinfection of glucometers. All licensed nursing staff who were interviewed reported they had received the required in-service training on 2/18/2025 or prior to beginning their next assigned shift after 2/18/2025. The educational in-services stressed using individually

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assigned glucometers for each resident requiring blood glucose monitoring and storing each individual assigned glucometer in an individually labeled glucometer pouch with resident's name and room number. The in-service training also included a review of the manufacturer's instructions for the facility's glucometers and disinfectant wipes related to disinfection of the glucometer and completion of a returned demonstration of the proper procedure for effective glucometer disinfection. Nurse observation in conducting a blood glucose check and subsequent glucometer disinfection completed the task without difficulty. Individually assigned resident glucometers were observed stored on the medication carts in closed labeled pouches with resident's name and room number. Each medication cart was observed with a canister of EPA disinfectant wipes. The nursing staff were recording verification of individually assigned glucometers and EPA disinfectant wipes on each medication cart at the change of shift. There was an unused unlabeled new glucometer observed on each medication cart that licensed nursing staff validated through interviews the new unused glucometers were available for new admissions, replacement of a resident's individually assigned glucometer or in an emergency as needed. To prevent the likelihood of a new glucometer used as a shared glucometer, the facility removed the new, unused glucometers from each medication cart and relocated the storage of the new unused glucometer into the medication storage rooms on each unit. There were no further concerns identified during either the interviews or observations.

The immediate jeopardy removal date of 2/19/25

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was validated.

2. The manufacturer's operator manual revised 10/2019 for Resident #32's assigned glucometer provided instructions for cleaning and disinfecting the glucometer used at the facility. It stated, in part: to minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed after each use. The manufacturer's instructions listed approved EPA registered wipes for cleaning and disinfecting the glucometer and stated other EPA registered wipes may be used for disinfecting the glucometer used by the facility.

The cleaning and disinfecting procedure for Resident #32's individually assigned glucometer included in part:
Step 5: using one EPA disinfectant towelette to wipe the entire surface of the glucometer horizontally and vertically to remove bloodborne pathogens and
Step 6: Treated surface must remain wet for the recommended contact time. Do not wrap the meter in a towelette.

The instructions for the EPA approved disinfectant wipes dated 2023 stated the minute wipe was an effective virucide, bactericide, tuberculocide and fungicide on hard non-porous surfaces. When using the disinfectant wipe, apply the wipe to a hard, non-porous surface (the glucometer), allowing it to remain wet for one minute and allow the surface to air dry.

On 2/18/2025 at 7:51 am, Medication Aide #1 (agency) was observed performing blood glucose monitoring using an individually assigned glucometer for Resident #32. After obtaining a

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blood glucose level, Medication Aide #1 was observed cleaning Resident #32's individually assigned glucometer with alcohol wipes.

On 2/18/2025 at 7:57am in an interview with Medication Aide #1, she explained Resident #32's glucometer needed to be disinfected after use and she cleaned the glucometer with an alcohol pad because she did not have any disinfected wipes on the 300-hall medication cart.

On 2/18/2025 at 10:25 am in a follow up interview with Medication Aide #1, she stated she received training less than a month ago at the facility on using disinfectant wipes to clean glucometers after use. She stated there were disinfectant wipes on the 300-hall medication cart, and she did not know the disinfectant wipes were on the 300-hall medication cart because she had not checked the 300-hall medication cart.

On 2/18/2025 at 11:50 am when interviewing Medication Aide #1 regarding her training in cleaning and disinfecting glucometers after resident use, she reported she had been informed on 2/18/2025 medication aides were not allowed to perform blood glucose monitoring at the facility and stated she would get a nurse to perform blood glucose monitoring. She explained she was in nursing school and had received training in performing blood glucose monitoring and had attended an educational in-service at the facility.

On 2/18/2025 at 12:22 pm in an interview with the Administrator, she stated medication aides could perform blood glucose monitoring if training and competency were documented. She explained Medication Aide #1 had received training from the

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| F 726 | Continued From page 90<br>agency company and was currently in nursing school where she received training.<br><br>On 2/18/2025 at 12:30 pm in an interview with the Director of Nursing, she stated in the last five weeks of employment she had not seen an orientation/competency form that agency staff completed for the facility.<br><br>On 2/18/2025 at 5:10 pm in follow up interview with the Director of Nursing, she stated Resident #32's individually assigned glucometer needed to be disinfected after each use using a disinfectant wipe and medications aides did not perform blood glucose monitoring at the facility. She stated blood glucose monitoring was completed by licensed nurses in the facility and not medication aides.<br><br>A skills competency rating dated 9/30/2024 from the agency company indicated Medication Aide #1 performed glucose monitoring daily to weekly and was proficient in the task.<br><br>An educational in-service roster dated 9/11/2024 and 9/12/2024 on cleaning glucometers between patients every time for infection control practices stated to allow the glucometer to air dry 2 minutes after wiping with purple wipes and place on a clean surface to dry. Medication Aide #1 signature was included on the roster to indicate she had received the education. | F 726 | | |
| F 727 SS=D | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility | F 727 | | 3/25/25 |

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| F 727 | Continued From page 91<br>must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours for 3 of 92 days reviewed for staffing (12/30/24, 1/2/25 and 1/3/25).<br><br>The findings included:<br><br>Review of the facility's daily staff posting and staffing schedules from 11/1/24 through 1/31/25 revealed the following:<br><br>a. On 12/30/24 the daily staff posting indicated a daily census of 113.<br><br>Review of the staffing schedule revealed there was no RN working on any shift that day.<br><br>b. On 1/2/25 the daily staff posting indicated a daily census of 118.<br><br>Review of the staffing schedule revealed there was no RN working on any shift that day.<br><br>c. On 1/3/25 the daily staff posting indicated a daily census of 119. | F 727 | F727<br>1. No Residents were affected by this practice<br>2. Current residents are at risk to be affected<br>3. On 03/18/2025 the Director of Nursing and administrator and scheduler was educated by the Regional Director of Clinical Services regarding the need to ensure a Registered Nurse is scheduled for at least 8 hours per day 7 days per week. The Director of Nursing and Administrator will continue to review the monthly staffing schedule daily to ensure a Registered Nurse is scheduled for 8 hours a day. Any Registered Nurse who cannot work their assigned shift must call in directly to the Director of Nursing. The Administrator and Director of Nursing have reviewed the facilities current recruitment plan for Registered Nurses. Any new scheduler, Director of Nursing or Administrator will be educated during orientation process.<br>The DON/Administrator/designee will monitor the nursing schedule daily to | |

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| F 727 | Continued From page 92<br><br>Review of the staffing schedule revealed there was no RN working on any shift that day.<br><br>In an interview with the Scheduler on 2/22/25 at 5:39 pm, she stated she worked on the schedule 2 weeks in advance verifying RN coverage. The Scheduler indicated she reported to the Administrator if there was no RN coverage. The Scheduler stated she did not have RN coverage for 12/30/24, 1/2/25, and 1/3/25.<br><br>An interview with the Administrator on 2/22/25 at 5:00 pm revealed she was still looking for evidence of RN coverage for 12/30/24, 1/2/25 and 1/3/25. The Administrator stated there should be an RN for 8 consecutive hours in the building. There was no additional information provided by the Administrator. | F 727 | ensure there is 8 hours of consecutive RN coverage for the center. The Director of Nursing/administrator/designee will share schedules with Regional Director of Clinical Services and Regional Vice President of Operations weekly x 4, then 3x week x 4, then weekly x 4.<br>4. The results of the daily review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the audits will be completed randomly.<br>5. Date of completion: 3/25/2025 | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>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.<br><br>§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.<br><br>§483.45(b) Service Consultation. The facility | F 755 | | 3/25/25 |

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| F 755 | Continued From page 93<br>must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff and Pharmacist #1 interviews, the facility failed to complete a return pharmacy form and return discontinued non-controlled medications and controlled medications for 11 of 11 residents whose controlled medications were observed located in the Director of Nursing office (Resident #70, Resident #113, Resident #96, Resident #400, Resident #71, Resident #85, Resident #14, Resident #401, Resident #402, Resident #124, Resident #95).<br><br>Findings included:<br><br>The facility's policy "Disposal of Medications and Medications-Related Supplies: Returning Medications to Pharmacy" with no reviewed or revised date stated with the exception of controlled substances, discontinued or unused medications were returned to the provider pharmacy for credit whenever possible. It also stated in part: for each medication returned, an | F 755 | F755<br>1. Narcotics not in use were returned to the pharmacy on 2/24/2025<br>2. Med Carts were audited on 3/25/2025 to ensure all narcotics not in use were returned to pharmacy. This was completed by the Director of Nursing<br>3. Education to licensed nurses including agency to keep narcotics on the med carts until Director of Nursing obtains them to send back to the pharmacy. Education was initiated on 3/19/2025. Any licensed nurse will not be allowed to work until education received, Agency licensed nurses will receive education prior to the start of their shift<br>Any new licensed nurse will receive education during the orientation process by the Director of Nursing or designee.<br>4. Director of Nursing will complete an audit of each med carts to sent narcotics back that are not in use weekly x | |

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| F 755 | Continued From page 94<br>entry was made on the medication return form and included the date, medication name and strength, quantity and prescription number. Medications to be returned to the pharmacy should be secured until the time of pick up.<br><br>On 2/17/2025 at 7:17 am, an interview and observation was conducted. Medication Aide #4 and Nurse #15 were observed counting the controlled medications at the change of shift narcotic count for the 300-hall medication cart. Medication Aide #4 stated controlled medications were returned to the pharmacy at night. She stated the unit managers removed the controlled medications off the medication carts and completed the return to pharmacy form to return controlled medications to the pharmacy.<br><br>A review of the controlled substance count sheet for 300-hall medication cart on 2/24/2025 recorded three controlled medication cards for Resident #14 were removed on 2/17/2025: Oxycodone 5mg (milligrams), Oxycodone 10mg and Lorazepam 0.5mg and the initials of the DON as the person that removed the controlled medications.<br><br>On 2/24/2025 at 9:38 am in a phone interview with Nurse # 15, she stated the Director of Nursing (DON) removed discontinued controlled medications from the medications carts to return the controlled medications to the pharmacy and the DON removed Resident #14 controlled medications, Oxycodone 10mg and 5mg medication cards off the 300-hall medication cart on 2/17/2025.<br><br>On 2/20/2025 at 4:30 pm an interview was conducted with the DON, who resigned on | F 755 | 12weeks, then monthly x 2<br>The administrator or designee will audit the DON office weekly to ensure that narcotics are stored appropriately and sent back to the pharmacy. This will be completed weekly x 12, then monthly x 2.<br>5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br><br>6. Date of completion 3/25/2025 | |

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2/19/2025. During the interview the DON informed the surveyor there were controlled medications in a filing cabinet behind the locked door of the DON's office. She stated the controlled medications were not sent back to the pharmacy because she did not know the procedure in returning controlled medications to the pharmacy. There was no further information was obtained in the interview.

On 2/22/2025 at 4:30 pm, the Administrator and Corporate Nurse Consultant #1 accompanied the surveyor to the DON's office for an observation of the filing cabinet in the DON's office. The DON's office was observed located on a short hall from nursing station #1 beside the residents' shower room. The Administrator was observed unlocking the door to the DON's office. Upon entrance to the DON's office there was a large gray pharmacy bin (24 inches x 16 inches) observed located behind the DON's desk on the floor in front of the filing a cabinet and there was a large size paper bag sitting on top of the gray bin. The Administrator and the Corporate Nurse Consultant #1 stated the medications observed in the gray bin and paper bag were residents' non-controlled medications. The big grey bin was filled with residents' non-controlled medication cards so the top flaps of the gray bin could not close. The large size paper bag sitting on top of the gray bin was three-fourth full of more non-controlled medications observed inside. There was one filing cabinet that was located behind the DON's desk in the DON's office. The filing cabinet drawers were found to be unlocked and the Administrator stated the filing cabinet did not have a lock. Controlled medications were observed removed by the Administrator from the third drawer from the top of the unlocked filing

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cabinet and verified with Corporate Nurse Consultant #1 that included:

- Resident #70: Hydrocodone- Acetaminophen (an opioid/pain medication) 7.5-325 milligrams (mg): Fifty-two tablets were observed in the medication card.
Zolpidem Tartrate (a sedative -hypnotic used to treat insomnia) 5mg: Twenty-five tablets were observed in one medication card.
Zolpidem Tartrate 5 mg: Twenty-nine tablets were observed in second medication card.

- Resident #113: Lorazepam (a medication used to treat anxiety and insomnia) 1mg: Sixty-six tablets were observed in the medication card.

- Resident #96: Lorazepam 1 mg: Thirty tablets were observed in the medication card. Morphine Sulfate solution (an opioid) 100mg per 5 milliliters (ml): Twenty eight ml were observed in the bottle.

- Resident #400: Pregabalin (a medication used to treat seizures and anxiety) 75 mg: Twenty -four tablets were observed in the medication card.

- Resident #71: Morphine Sulfate solution 100mg per 5 ml: Less than a milliliter was observed in the bottle. Morphine Sulfate solution 100mg per 5 ml. Fifteen milliliters was observed in a bottle.

- Resident #85: Methadone Hydrochloride (an opioid) 10mg: Five tablets were observed in the medication card. Acetaminophen and Hydrocodone Bitartrate 325mg / 7.5mg: Five tablets were observed in a medication card.

- Resident #14: Lorazepam 0.5 mg: Three tablets were observed in the medication card.

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- Resident #401: Tramadol (an opioid) 50 mg: Two tablets were observed in the medication card. Naltrexone (used to treat alcohol and opioid use disorders to reduce cravings and help control physiological dependence) 50mg: Sixteen tablets were observed in the medication card.

- Resident #402: Lorazepam 1mg: Sixty tablets were observed in the medication card. Lorazepam 1mg: Ninety tablets were observed in the medication card.

- Resident #124: Oxycodone/Acetaminophen (an opioid) 5/325: Four tablets were observed in the medication card.

- Resident # 95: Buprenorphine (an opioid) patch 100 micrograms per hour: Two patches were observed.

On 2/24/2025 at 7:50 am in a phone interview with the DON, she stated on 2/16/2025 when the state survey began, residents' non-controlled and controlled medications that needed to be returned to the pharmacy were collected by herself, Unit Manager #1, Unit Manager #2 and the Interim DON from the medication carts and residents' controlled medications were placed in the filing cabinet in the DON office for storage until the controlled medications could be returned to the pharmacy. She stated on 2/17/2025 and 2/18/25 nursing staff randomly gave her discontinued controlled medications off the medications cart. She stated she placed the controlled medications in the filing cabinet (that could not be locked) in the DON's office until she could return to the pharmacy. She stated she was busy with the state survey and did not return the non-controlled

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and controlled medications to the pharmacy before resigning from the facility on 2/19/2025. The DON stated the DON's office door would have been left open and unlocked to go across the hall to the Unit Manager #1 office. The DON stated since starting at the facility 5 ½ weeks ago, she had not received an orientation on how to return non-controlled and controlled medications to the pharmacy. She stated she was the only person with a key to the DON's office and the non-controlled medications and the controlled medications that were to be stored on the medications carts until they were returned to the pharmacy.

On 2/24/2025 at 8:11 am in a phone interview with Unit Manager #1, she explained she would remove discontinued controlled medications off the medications carts and gave them to the DON directly to return to the pharmacy. She stated she knew the DON kept controlled medications in her office until she could send the controlled medications back to the pharmacy. She stated all nurses could complete the return to pharmacy form and place the non-controlled medications in the gray pharmacy bin for residents' non-controlled medications that were to return to the pharmacy.

On 2/24/2025 at 9:44 am in a phone interview with the Pharmacist #1, he explained grey pharmacy bins were used to return non-controlled medications to the pharmacy. He stated non-controlled medications were to be listed on a return to pharmacy form and returned to the pharmacy in the gray bin. He stated the DON was informed of the process of how to return controlled medications that were to be returned to the pharmacy and not to be destroyed at the

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facility. He explained the process as: list the controlled medications on a return to pharmacy triple form, place one copy of the triple form with the controlled medications in the red pharmacy tote, use controlled medication zip tie to secure red tote and write number of the zip tie on the return to pharmacy triple form. He stated pharmacy picked up the red pharmacy tote when delivering medications Monday through Saturday and the controlled medications were verified with the controlled medications listed on the return to pharmacy triple form. He stated the DON was to retain the other two copies of the return to pharmacy triple form.

On 2/22/2025 at 4:10 pm in an interview with Interim Director of Nursing, she stated she understood unit managers were removing controlled medications off the medication carts and giving them to the DON, and the DON was responsible in ensuring controlled medications were returned to the pharmacy. The Interim DON stated Resident #14's controlled medications should have been removed from the 300-hall medication cart and returned to the pharmacy immediately after Resident #14's death.

On 2/22/2025 at 5:00 pm an interview was conducted with the Administrator and Corporate Nurse Consultant #1. The Administrator and Corporate Nurse Consultant #1 both stated non-controlled medications and controlled medications should be returned to the pharmacy and controlled medications should be stored in the medication carts until collected by the DON to returned to the pharmacy due to the medications carts providing a double lock system for the controlled medications. They stated non-controlled and controlled medications were

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| F 755 | Continued From page 100<br>not to be stored in the filing cabinet in the DON's office. | F 755 | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not | F 756 | | 3/25/25 |

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| F 756 | Continued From page 101<br>limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff and Consultant Pharmacist interviews the facility failed to act on recommendations made by the consultant pharmacist and maintain documentation of the physician's review and response to the pharmacist's findings for 3 of 5 residents reviewed for drug regimen review (Resident #17, Resident #67 and Resident #11).<br><br>The findings included:<br><br>1. Resident #17 was admitted to the facility on 7/4/23 with diagnoses that included depression and dementia.<br><br>Resident #17's most recent Minimum Data Set (MDS) assessment dated 1/1/25, a quarterly revealed Resident #17 had severe cognitive impairment.<br><br>Review of Resident #17's medication orders revealed she was taking Melatonin 3 milligrams at bedtime (ordered 12/3/24), Remeron 7.5 milligrams daily( ordered 1/3/25), Miralax 17 grams daily (ordered 5/30/24), Bisacodyl DR 5 milligrams twice daily every other day(ordered 12/3/24), and Senna S 8.6 milligrams/50 milligrams once daily (ordered 12/4/24).<br><br>A medication regimen review completed by the Pharmacist dated 9/18/24 recommended discontinuing Remeron or Melatonin with no response or rationale for continuing both | F 756 | F756<br>1. Residents # 17, #67, # 11 pharmacy recommendations were completed.<br>2. The last 3 months of pharmacy recommendations were reviewed by the Director of Nursing and forwarded to the provider for review. This was completed on 3/25/2025<br>3. Education was provided to the nursing leadership team by the Regional Director of Clinical Services to ensure the consultant pharmacy recommendations are reviewed and acted upon timely. This education was completed on 3/18/2025. Any nursing leadership team members will not be allowed to work until education received.<br>New nursing leadership team members will receive education during the orientation process by the Director of Nursing or designee.<br>Audit of pharmacy recommendations will be completed by the Director of Nursing weekly x 12 weeks then monthly x 2.<br>4. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br>5. Date of completion : 3/25/2025 | |

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medications.

A medication regimen review completed by the Pharmacist dated 12/6/24 recommended discontinuing Miralax, Bisacodyl or Senna with no response or rationale for continuing all three medications.

An interview was conducted with the Director of Nursing on 2/18/25 at 4:52 PM who stated she was not aware of the process for drug regimen reviews and had been unable to establish one since she became employed by the facility on 12/9/24.

During an interview with the Consultant Pharmacist on 2/22/25 at 5:41 PM she stated her medication regimen reviews were emailed to the Director of Nursing, Assistant Director of Nursing and Administrator and she was unsure what the facility's process for following up on those recommendations.

2. Resident #67 was admitted to the facility on 5/29/21 with diagnoses that included anxiety disorder and depression.

Resident #67's most recent Minimum Data Set (MDS) assessment dated 12/25/24, a quarterly revealed he was cognitively intact.

Review of Resident #67's medication orders revealed he was taking Amlodipine 10 milligrams daily (ordered 11/9.24), Valsartan 160 milligrams daily(ordered 11/9/24),, Lasix 20 milligrams daily (ordered 11/9/24), Trazadone 50 milligrams every 24 hours as needed (ordered 1/10/25), Abilify 2 milligrams at bedtime (ordered 11/22/24), and Klonopin 1 milligram at bedtime (ordered

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11/27/24).

A medication regimen review completed by the Pharmacist dated 8/8/24 recommended discontinuing either the Abilify, Klonopin, or Trazadone with no response or documented rationale.

A medication regimen review completed by the Pharmacist dated 11/5/24 recommended discontinuing Amlodipine or Lasix with no response or documented rationale.

A medication regimen review completed by the Pharmacist dated 12/6/24 recommended either a clinical rationale for as needed Trazadone 50 milligrams every 24 hours or to discontinue the medication with no response or documented rationale. The review further recommended discontinuing either Amlodipine or Lasix with no response or documented rationale.

An interview was conducted with the Director of Nursing on 2/18/25 at 4:52 PM who stated she was not aware of the process for drug regimen reviews and had been unable to establish one since she became employed by the facility on 12/9/24.

During an interview with the Consultant Pharmacist on 2/22/25 at 5:41 PM she stated her medication regimen reviews were emailed to the Director of Nursing, Assistant Director of Nursing and Administrator and she was unsure what the facility's process for following up on those recommendations.

3. Resident #11 was admitted to the facility on 8/08/22 with diagnoses including hypothyroidism

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(low thyroid hormone levels).

Resident 11's physician orders dated 7/01/24 documented an order for levothyroxine 50 micrograms (mcg) once a day for hypothyroidism.

Resident #11's laboratory results dated 8/09/24 revealed her Thyroid Stimulating Hormone (TSH) test result was 0.23. (The normal range was between 0.4 and 4.5). The results indicated Resident 11's Physician, Physician #2, reviewed the results of the test on 8/14/24.

Resident #11's Physician progress notes dated 8/14/24 documented she had a history of hypothyroidism and continued on thyroid replacement. Physician #2 noted to continue to monitor her TSH levels.

Review of Resident #11's physician orders dated 8/15/24 revealed there was no order for a repeat TSH laboratory to test.

Resident #11's pharmacy Medication Regimen Review completed by the Pharmacist on 9/12/24 documented she was taking Levothyroxine 50 mcg po daily; his/her most recent TSH on 8/9/24 revealed a level of 0.23 "which was quite low." The pharmacist recommended to consider decreasing her Levothyroxine at that time and to recheck her TSH level in 6 weeks (which would have occurred around 10/21/24). There was no documentation on the recommendation from Physician #2 or any other provider.

Resident #11's Physician orders dated 11/12/24 documented an order for levothyroxine 100 mcg one time a day due to a TSH result of 0.23 mIU/L. There was no order or results for a TSH test.

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| F 756 | Continued From page 105<br><br>Physician #2 was unable to be interviewed during the survey.<br><br>In an interview on 2/22/25 at 5:31 PM, the Interim Director of Nursing (DON) said the pharmacy recommendation should have been followed up on earlier than 11/12/24. She said there should have been an order to check Resident #11's TSH but she didn't see an order for a repeat TSH in the clinical record. She was not sure why the pharmacy recommendation was not acted on in September 2024.<br><br>In an interview on 2/22/25 at 6:34 PM, the Administrator and Corporate Nurse Consultant #1 said Physician #2 reviewed the TSH results soon after the results were available in August 2024, but didn't make any changes to her levothyroxine at that time. However, the pharmacy recommendation should have been addressed and an order written to address how to monitor the TSH levels as noted by Physician #2. | F 756 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41% for 2 | F 759 | F759<br>1. Medication aide #4 and Nurse # 3 received education on the 6 rights of medication administration. The physician was notified, and no adverse outcome | 3/25/25 |

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| F 759 | Continued From page 106<br>of 6 residents (Residents #59 and #28) observed during the medication administration observation.<br><br>The findings included:<br><br>1. Resident #59 was admitted to the facility on 1/31/2025 with diagnoses including depression.<br><br>Resident #59's physician's orders dated 1/31/2025 included Olanzapine 5 milligrams at bedtime for mood stabilizer.<br><br>An observation on 2/18/25 at 8:47 am revealed due to technical difficulties, electronic medication administration records (MAR) were not available and the facility had printed Medication Aide #4 paper copies of Resident #59's MAR. Before starting medication preparation, Medication Aide #4 was observed asking Resident #59 about her calcium tablet which Resident #59 refused. Medication Aide #4 was observed returning to the medication cart and preparing four medications for administration to Resident #59. Each medication (Levofloxacin, Divalproex Sodium, Propranolol and Olanzapine) was in a pharmacy filled medication card that Mediation Aide #4 handed to the surveyor to enter the medication information for each medication individually before Medication Aide #4 removed the medication from the card and placed the medication into a medication cup with applesauce. Four tablets were verified with Medication Aide #4 in the medication cup. On 2/18/2025 at 9:00 am, Medication Aide #4 was observed administering Resident #59 the four medications with applesauce.<br><br>On 2/22/2025 at 7:05 pm in an interview with Medication Aide #4, she recalled Resident #59 | F 759 | was noted.<br>2. Current residents are at risk<br>3. Education began on 3/19/2025 by the Director of Nursing or designee on the six rights of medication administration to current licensed nurses and certified medication aides staff including agency staff.<br>Any licensed nurses and certified medication aides will not be allowed to work until education has been completed.<br>Agency staff will be provided with education prior to beginning of shift.<br>New licensed nurses and certified medication aides will receive education during the orientation process.<br>4. The Director of Nursing or designee will do medication pass observations 3 nurses or medication aides weekly x 4 weeks, then 2 nurses or medication aide weekly x 4 weeks, then 1 nurse and medication aide weekly x 4 weeks, then 1 nurse or medication aide monthly x 2.<br>5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br>6. Date of completion: 3/25/2025 | |

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refusing the calcium tablet and only giving Resident #59 a pink pill (Divalproex Sodium) and a green pill (Propranolol). When Medication #4 was reminded Resident #59 received Levofloxacin, an antibiotic, she stated she gave three tablets and only administered the medication that was on the printed MAR scheduled for 9:00 am. Medication #4 stated Olanzapine was scheduled for 9:00pm, and she did not give Olanzapine on 2/18/2025 at 9:00 am. Medication #4 stated she recorded administration of the medications on Resident #59's electronic MAR at a later time.

A review of Resident #59's electronic February 2025 MAR on 02/22/25 indicated Medication Aide #4 recorded the medications Levofloxacin, Divalproex Sodium and Propranolol were administered on 2/18/2025 as scheduled. The medication, Olanzapine, was scheduled at 9:00 pm on Resident #59's February 2025 MAR and was recorded administered at 9:00pm on 2/18/2025 by Nurse #6.

On 2/22/2025 at 8:42 pm in an interview with Corporate Nurse Consultant #1, she stated Resident #59 medications were to be administered and documented on Resident #59's MAR as ordered by the physician when scheduled.

2. Resident #28 was admitted to the facility on 9/22/2019 with diagnoses including anemia and fracture of a bone.

A review of Resident #28's current physician's orders revealed her medication orders included a combination medication containing calcium carbonate 300 milligrams (mg) with 800 units

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Vitamin D.

On 2/18/2025 at 9:22 am, Nurse #3 was observed preparing seven medications for administration to Resident #28. The medications included one chewable tablet of a combination medication containing 600 milligrams (mg) calcium carbonate with 800 units Vitamin D taken from a bottle labeled by the pharmacy for Resident #28. On 2/18/2025 at 9:31am, Nurse #3 was observed administering Resident #28 the calcium and vitamin D chewable tablet.

On 2/22/2025 at 11:30 am, re-observed Resident #28's bottle of chewable calcium tablet with vitamin D and mineral dispensed by the pharmacy that read calcium 600 mg and Vitamin D 800 units and minerals.

Resident #28's February 2025 Medication Administration Record recorded Nurse #3 administered calcium carbonate 300 mg and vitamin D 800 units with minerals on 2/18/2025.

On 2/22/2025 at 10:28 am in a phone interview with Nurse # 3, she explained the calcium vitamin D3 mineral chewable tablet was administered out of the bottle dispensed by the pharmacy labeled with Resident #28's name. She stated the dose of the calcium vitamin D3 mineral chewable tablet would be the dose the pharmacy dispensed (600 / 800 units tablets) and she had been administering Resident #28 the medication from the pharmacy labeled bottle. Nurse #3 stated the dose of Resident #28's calcium vitamin D3 mineral chewable tablet administered should be the same as the physician's order.

On 2/22/2025 at 8:42 pm in an interview with

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| F 759 | Continued From page 109<br>Corporate Nurse Consultant #1, she stated Resident #28's the calcium vitamin D3 mineral chewable tablet was to be administered as ordered by the physician. | F 759 | | |
| F 760 SS=E | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and staff , Pharmacist Consultant, and Physician interviews, the facility failed to administer antibiotic medications as ordered by the physician which resulted in a delay in starting antibiotic therapy for 2 of 4 residents reviewed for administration of significant medications (Resident #90 and Resident # 59).<br><br>Findings included:<br><br>1. Resident # 90 was admitted to the facility on 1/21/2025 with diagnoses including diabetes mellitus and heart failure.<br><br>The admission Minimum Data Set (MDS) assessment dated 1/28/2025 indicated Resident #90 was moderately cognitively impaired. The MDS was also coded Resident #90 as receiving antibiotics as a medication.<br><br>Physician orders dated 2/4/2025 at 3:32 pm and written by the Wound Treatment Nurse included Clindamycin HCL (an antibiotic) 300 milligrams three times a day for 10 days for cellulitis.<br><br>The February 2025 Medication Administration | F 760 | F760<br>1. Resident #90 and #59 received antibiotics as ordered<br>2. Current residents on antibiotics audited to ensure full treatment received. This will be completed by 3/25/2025.<br>3. Education to licensed nurses including agency staff by the Director of Nursing or designee timely delivery of medications, where to get new medications and notification to provider if unable to obtain new medication began on 3/19/2025.<br>Any licensed nurse will not be allowed to work until education completed. Agency staff will receive education by the Director of Nursing or designee prior to the start of their shift.<br>Any new licensed nurse will receive education during the orientation process by the Director of Nursing or designee.<br>4. Audit will be completed by the Director of Nursing or designee to ensure new medications initiated. This will be done 5x week x 4 weeks, 3xweekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 | 3/25/25 |

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| F 760 | Continued From page 110<br>Record (MAR) for Resident #90 recorded Clindamycin HCL 300mg milligrams was not started at 9:00 pm on 2/4/2025 as scheduled. Resident #90's MAR recorded administration of the first dose of Clindamycin 300mg on 2/5/2025 at 9:00 am.<br><br>There was no nursing documentation related to Resident #90's Clindamycin administration for 2/4/2025.<br><br>On 2/21/2025 at 5:07 pm in a phone interview with Nurse #9, she was unable to recall if Resident #90's Clindamycin was delivered to the facility on 2/4/2025 to administer at 9:00pm as scheduled. She stated she didn't have access to the medication automated dispensing system at the facility and was not aware Clindamycin 300mg tablets were in the medication automated dispensing system. Nurse #9 stated she called the pharmacy to inform them the facility had not received Resident #90's Clindamycin on 2/4/2025.<br><br>On 2/21/2025 at 4:53 pm in a phone interview with Pharmacist Consultant #1, she stated Resident #90's order for Clindamycin 300mg was entered into the pharmacy system on 2/4/2025 at 3:32pm, and per the signed delivery slip, the medication was delivered to the facility on 2/4/2025 at 9:38 pm. Pharmacist Consultant #1 further stated the facility's medication automated dispensing system was filled in January 2025 and contained Clindamycin 300mg tablets.<br><br>On 2/21/2025 at 5:40 pm in a phone interview with Pharmacist #1, he stated that when the facility reported not receiving a medication, the pharmacy would resend or when in the facility's | F 760 | 5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br>6. Date of completion : 3/25/2025 | |

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medication automated dispensing system, have the nursing staff remove from the medication automated dispensing system to administer to the resident. Pharmacist #1 stated the pharmacy had to document why a medication was resent to the facility and there was no documentation that Resident #90's Clindamycin medication was resent to the facility. Pharmacist #1 stated Resident #90's order for Clindamycin was filled and sent to the facility on 2/4/25.

On 2/22/2025 at 3:59pm in an interview with the Interim Director of Nursing, she stated that since Resident #90's medication, Clindamycin, was delivered to the facility at the time scheduled for administration, Nurse #9 should have administered the dose scheduled for 2/4/2025 at 9:00 pm. She stated there was a medication automated dispensing system that served as a back-up resource for medications. She stated the former DON had not provided the nursing staff or herself with access to the medication automated dispensing system.

On 2/21/2025 at 4:35 pm in a phone interview with Physician #1, he stated when Resident #90's Clindamycin 300mg was ordered, the medication should have been started as soon as possible because the earlier antibiotics were started, the better it was for Resident #90 skin infection. Physician #1 stated there was no harm to Resident #90 with the medication, Clindamycin 300mg tablets administration starting on 2/5/2025.

2. Resident #59 was admitted to the facility on 1/31/2025 with diagnoses including Parkinson's disease.

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The admission Minimum Data Set (MDS) assessment dated 2/6/2025 indicated Resident #59 was cognitively intact and was incontinent of urine and stool. Resident #59 was not coded for the use of antibiotics on the MDS dated 2/6/2025.

Resident #59's urine specimen collected on 2/12/2025 reported the urine contained bacteria, squamous epithelial cells (flat, scale-like ells that line the organs that may appear in the urine due to an infection) mucus and leukocyte esterase (enzyme produced by white blood cells) in the urine.

Physician orders dated 2/14/2025 at 9:41 am for Resident #59 included Levofloxacin (antibiotic use to treat bacterial infections) 500 milligrams tablet one time a day for urinary tract infection for seven days and the ordered indicated a start time of the medication on 2/15/2025 at 9:0 0am.

The February 2025 Medication Administration Record (MAR) for Resident #59 indicated Levofloxacin 500mg that was scheduled for 9:00 am on 2/15/2025 was not given and the space on the MAR on 2/15/2025 was marked with the number 9 that was referenced as other/see progress note. Resident #59 received the first dose of Levofloxacin on 2/16/2025 during the scheduled time at 9:00 am.

There was no nursing documentation that referenced administration of Resident #59's Levofloxacin on 2/15/2025.

On 2/22/2025 at 12:30 pm in an interview with Medication Aide #6, she stated on 2/15/2025 at 9:00am, Levofloxacin was not available to administer to Resident #59 and wrote a nurse's

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note stating the medication was on order. She stated the medication had not arrived from the pharmacy and as a medication aide, she could not get medications out of the medication automated dispensing system. Medication Aide #6 stated she informed Nurse #2 she didn't have Resident #59's antibiotic on 2/15/2025 so the medication could be removed from the medication automated dispensing system or to call the pharmacy to send the medication. She explained due to Resident #59 not receiving the first dose of antibiotic as scheduled on 2/15/2025, Nurse #2 should have recounted the number of days Levofloxacin was to be given with 2/16/2025 as the start day to ensure the medication was given for seven days as ordered.

On 2/22/2025 at 1:01 pm in an interview with Nurse #2, she stated she did not recall Medication Aide #6 telling her Resident #59's Levofloxacin was not available to administer as scheduled on 2/15/2025. She stated she was an agency nurse and agency nurses did not have access to the medication automated dispensing system to obtain medications not received from pharmacy. She explained she would have informed the unit manager because they have access to the medication automated dispensing system or called the pharmacy to receive the medication for Resident #59. She stated there was none of Resident #59's Levofloxacin medication left in the medication cart and thought she had completed receiving the seven days of administration. After looking at Resident #59's MAR, she stated the MAR did not record Resident #59 receiving a dose of the antibiotic on 2/15/2025 and received the antibiotic for only six days. She explained she would need to call the physician for further orders.

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| F 760 | Continued From page 114<br><br>On 2/21/2025 at 4:53 pm in a phone interview with Pharmacist Consultant #1, she stated the facility's medication automated dispensing system was filled in January 2025 and the medication, Levofloxacin, would have been available in the medication automated dispensing system if it had not been delivered by the pharmacy at the time scheduled<br><br>On 2/22/2025, a review of the February 2025 MAR recorded Resident #59 only received 6 days of the antibiotic instead of 7 days as ordered by the physician due to Resident #59 not receiving Levofloxacin 500mg on 2/15/2025.<br><br>On 2/22/2025 at 4:06 pm in an interview with the Interim Director of Nursing, she stated Levofloxacin was a medication stored in the medication automated dispensing system and Nurse #2, an agency nurse, would not have had access to the medication. She stated that when Resident #59 did not receive Levofloxacin on 2/15/2025, Nurse #2 should have called the physician to reset the seven days for Resident #59 to receive the antibiotic as ordered.<br><br>On 2/21/2025 at 4:35 pm in a phone interview with Physician #1, he explained the earlier antibiotics were started, the better it was for the resident and it would have been better if Resident #59's antibiotic would had been started earlier as ordered on 2/15/2025. He stated there was no change in Resident #59's condition and did not know of any harm to Resident #59 due to the antibiotic starting on 2/16/2026. | F 760 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2) | F 761 | | 3/25/25 |

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| F 761 | Continued From page 115<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and staff and Pharmacist interviews, the facility failed to maintain controlled medications on the medication carts that provided a separately locked and permanently affixed compartment for storage until the controlled medications were returned to the pharmacy for 1 of 1 filing cabinet observed storing control medications (Director of Nursing's filing cabinet).<br><br>Findings included: | F 761 | F761<br>1. Narcotics not in use were returned to the pharmacy on 2/24/2025<br>2. Med Carts were audited on 3/25/2025 to ensure all narcotics not in use were returned to pharmacy. This was completed by the Director of Nursing<br>3. Education to licensed nurses including agency to keep narcotics on the med carts until Director or Nursing obtains them to send back to the pharmacy. | |

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| F 761 | Continued From page 116<br>On 2/18/2025 at 5:30 pm, the DON's office door was observed open while the DON was observed in Unit Manager #1's office for two minutes with Unit Manager #1's door closed.<br><br>On 2/20/2025 at 4:30 pm an interview was conducted with the Director of Nursing (DON), who resigned on 2/19/2025. During the interview the DON informed the surveyor there were controlled medications in a filing cabinet behind the locked door of the DON's office. No further information was obtained in the interview.<br><br>On 2/22/2025 at 4:10 pm in an interview with the interim Director of Nursing (DON), she stated the DON was responsible for sending back controlled medications to the pharmacy. She stated controlled substances were stored on the medications carts and removed by the DON as needed to return to the pharmacy. She stated since beginning the role as interim DON on 2/19/2025, she had not received any controlled medications from the medication carts to return to the pharmacy.<br><br>On 2/22/2025 at 4:25 pm in an interview with the Administrator, she stated when the Director of Nursing resigned on 2/19/2025, she informed the facility of the controlled medications stored in the filing cabinet in the DON's office. The Administrator stated she and the Lead Administrator in the area confirmed there were controlled medications in the filing cabinet and the lock to the door of the DON's office was changed. She stated as the Administrator, she had the only key to the DON's office since 2/19/2025.<br><br>On 2/22/2025 at 4:30 pm, the Administrator and | F 761 | Education completed on 3/18/2025.<br>Any licensed nurse will not be allowed to work until education received, Agency licensed nurses will receive education prior to the start of their shift<br>Any new licensed nurse will receive education during the orientation process by the Director of Nursing or designee.<br>4. Director of Nursing will complete an audit of each med carts to sent narcotics back that are not in use weekly x 12weeks, then monthly x 2<br>The administrator or designee will audit the DON office weekly to ensure that narcotics are stored appropriately and sent back to the pharmacy. This will be completed weekly x 12, then monthly x 2.<br><br>5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br><br>6. Date of completion: 3/25/2025 | |

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Corporate Nurse Consultant #1 accompanied the surveyor to the DON's office for an observation of the filing cabinet in the DON's office. The DON's office was observed located on a short hall from nursing station #1 beside the residents' shower room. The Administrator was observed unlocking the door to the DON's office. There was one filing cabinet that was located behind the DON's desk in the DON's office. The filing cabinet drawers were found to be unlocked and the Administrator stated the filing cabinet did not have a lock. The following controlled medications were observed to be removed by the Administrator from the third drawer from the top of the unlocked filing cabinet and verified with Corporate Nurse Consultant #1:
- Resident #70: Hydrocodone- Acetaminophen (an opioid/pain medication) 7.5-325 milligrams (mg): Fifty-two tablets were observed in the medication card and 52 tablets were recorded on the controlled substance sheet.
Zolpidem Tartrate (a sedative -hypnotic used to treat insomnia) 5mg: Twenty-five tablets were observed in one medication card and 25 tablets were recorded on the controlled substance sheet.
Zolpidem Tartrate 5 mg: Twenty-nine tablets were observed in second medication card and 29 tablets were recorded on the controlled substance sheet.

- Resident #113: Lorazepam (a medication used to treat anxiety and insomnia) 1mg: Sixty-six tablets were observed in the medication card and 66 tablets were recorded on the controlled substance sheet.

- Resident #96: Lorazepam 1 mg: Thirty tablets were observed in the medication card. There was no controlled substance sheet for Resident #96's Lorazepam to verify that the count was accurate.

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Morphine Sulfate solution (an opioid) 100mg per 5 milliliters (ml): Twenty eight ml were observed in the bottle. There was no controlled substance sheet for Resident #96's Morphine Sulfate solution to verify that the amount was accurate.

- Resident #400: Pregabalin (a medication used to treat seizures and anxiety) 75 mg: Twenty -four tablets were observed in the medication card. There was no controlled substance for Resident #400's Pregabalin to verify that the count was accurate.
Clonazepam (used to treat seizures and panic disorder) 1mg: Five tablets were observed in the medication card. Thee was no controlled substance sheet for Resident #400's Clonazepam to verify that the count was accurate.

- Resident #71: Morphine Sulfate solution 100mg per 5 ml: Less than a milliliter was observed in the bottle. The controlled substance sheet recorded 0.5 ml as the amount in the bottle.
Morphine Sulfate solution 100mg per 5 ml. Fifteen milliliters was observed in a bottle. There was no controlled substance sheet for Resident #71's Morphine Sulfate solution to verify that the amount was accurate.
Lorazepam 1mg: Five tablets were observed in the medication card. There was no controlled substance sheet for Resident #71's Lorazepam to verify that the count was accurate.

- Resident #85: Methadone Hydrochloride (an opioid) 10mg: Five tablets were observed in the medication card. There was no controlled substance sheet for Resident #85's Methadone Hydrochloride to verify that the count was accurate.
Acetaminophen and Hydrocodone Bitartrate

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325mg / 7.5mg: Five tablets were observed in a medication card. There was no controlled substance sheet for Resident #85's Acetaminophen and Hydrocodone Bitartrate to verify the count was accurate.

- Resident #14: Lorazepam 0.5 mg: Three tablets were observed in the medication card. There was no controlled substance sheet for Resident #14's Lorazepam to verify the count was accurate.

- Resident #401: Tramadol (an opioid) 50 mg: Two tablets were observed in the medication card. There was no controlled substance sheet for Resident #14's Tramadol to verify the count was accurate.
Naltrexone (used to treat alcohol and opioid use disorders to reduce cravings and help control physiological dependence) 50mg: Sixteen tablets were observed in the medication card. There was no controlled substance sheet for Resident #401's Naltrexone to verify the count was accurate.

- Resident #402: Lorazepam 1mg: Sixty tablets were observed in the medication card and 60 tablets were recorded on the controlled substance sheet.
Lorazepam 1mg: Ninety tablets were observed in the medication card and 90 tablets were recorded on the controlled substance sheet.

- Resident #124: Oxycodone/Acetaminophen (an opioid) 5/325: Four tablets were observed in the medication card. There was no controlled substance sheet for Resident #124's Oxycodone/Acetaminophen to verify the count was accurate.

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- Resident # 95: Buprenorphine (an opioid) patch 100 micrograms per hour: Two patches were observed and two patches were recorded on the controlled substance sheet.

- Resident #403: Amphetamine and dextroamphetamine (a central nervous system stimulant) 15mg: There were no tablets observed in the filing cabinet and the control substance sheet recorded there should have been 43 tablets of Amphetamine and dextroamphetamine.
Tramadol 50 mg: There were no tablets observed in the filing cabinet and the control substance sheet recorded there should have been 43 tablets of Tramadol.
Pregabalin 200mg: There were no tablets observed in the filing cabinet and the control substance sheet recorded there should have been 19 tablets of Pregabalin.

On 2/22/2025 at 5:00 pm an interview was conducted with the Administrator and Corporate Nurse Consultant #1. The Administrator and Corporate Nurse Consultant #1 both stated controlled medications should be stored in the medication carts until collected by the DON to returned to the pharmacy due to the medications carts providing a double lock system for the controlled medications. They stated controlled medications were not to be stored in the filing cabinet in the DON's office and only door to the DON's office was able to be locked.

On 2/24/2025 at 7:50 am in a phone interview with the DON, she stated on 2/16/2025 when the state survey began, residents' non-controlled and controlled medications that needed to be returned to the pharmacy were collected by the DON, Unit

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Manager #1, Unit Manager #2 and the interim DON from the medication carts and residents' controlled medications were placed in the filing cabinet in the DON office for storage until the controlled medications could be returned to the pharmacy. She stated she was busy with the state survey and did not return the non-controlled and controlled medications to the pharmacy before resigning from the facility on 2/19/2025. The former DON stated since starting at the facility 5 ½ weeks ago, she had not received an orientation on how to return non-controlled and controlled medications to the pharmacy. She stated she was the only person with a key to the DON office and the non-controlled medications and the controlled medications that were to be stored on the medications carts until they were returned to the pharmacy were removed from the medication carts on 2/16/2025 due to the facility's history with diversion of controlled medications in October 2024.

On 2/21/2025 at 5:40 pm, a phone interview was conducted with Pharmacist #1 and Pharmacy Consultant #1. Pharmacist #1 stated due to a report of a diversion of controlled medications in October 2024, the facility was to return controlled medications back to the pharmacy as soon as possible and not keep stored in the medication carts in the facility. Pharmacist #1 reported the facility was to use a triple carbonate return to pharmacy form to list controlled medications returned to the pharmacy, placed in a pharmacy tote and secure the tote closed with a numbered zip tie. Pharmacist #1 stated the number of the zip tie was to be written on the triple carbonate return to pharmacy form and pharmacy totes were picked up at night when pharmacy delivered medications to the facility. Pharmacist Consultant

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#1 stated the pharmacy was not able to control when the facility returned non-controlled and controlled medications back to the pharmacy. Pharmacist Consultant #1 stated there had been issues with the facility not returning controlled medications timely. She stated on 1/5/2025 and 2/18/2025 when audits were conducted, there were no issues with the storage of controlled medications on the medication carts and the controlled medications accurately correlated with controlled medications sheets.

On 2/24/2025 at 8:11am in a phone interview with Unit Manager #1, she stated discontinued controlled medications were to remain stored on the medication carts and counted at the change of each shift for accuracy until the DON was present in the facility to collect when notified by the nursing staff and sign a sheet reporting when controlled medications were removed by the DON to return to the pharmacy. She stated this was the new practice from returning controlled medications stored in the medication cart to the pharmacy since October 2024. Unit Manager #1 further stated on 2/16/2024 she collected no controlled medications from the medication carts to give to the DON to return to the pharmacy. Unit Manager #1 explained controlled medications waiting to be returned to the pharmacy used to be stored on the 500-hall medication cart due to there were no resident admitted to the 500 hall. She stated since the 500-hall medication cart was storing resident medications, the DON was storing the controlled medications in the DON's office that had not been sent back to the pharmacy.

On 2/24/2025 at 8:49 am in a phone interview with Unit Manager #2, she stated she had been

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| F 761 | Continued From page 123<br>out of work since 2/15/2025 and was not at the facility on 2/16/2025 to remove controlled medications from the medication carts. She stated controlled medications were stored on the medications carts until the DON collected the controlled medications to return to the pharmacy. She stated she returned to work on 2/21/2025.<br><br>On 2/24/2025 at 9:56 am in a phone interview with the Administrator, she stated Unit Manager #2 had been out of work from 2/16/2025 to 2/20/2025. She explained that the DON informed her through an email of her resignation on the morning of 2/19/2025 and also informed her there were controlled medications in the filing cabinet in the locked DON's office. She stated the DON had a key to the DON office and the Administrator had a backup key to the DON office. She reported that when the Lead Administrator came to the facility on 2/19/2025 they went to the DON office and observed the controlled medications in the filing cabinet that did not lock. She stated the controlled medications were not counted with a nurse or returned to the pharmacy and remained in the unlocked filing cabinet. She explained she requested maintenance to change the lock to the DON's office. The Administrator stated the lock on the DON door was changed on 2/19/2025 by 12:00pm, she had the only key to the DON office. The Administrator stated she started on 12/30/2024 and was still learning the processes in storing and returning controlled medications to the pharmacy. | F 761 | | |
| F 801 SS=F | Qualified Dietary Staff<br>CFR(s): 483.60(a)(1)(2)<br><br>§483.60(a) Staffing<br>The facility must employ sufficient staff with the | F 801 | | 3/25/25 |

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appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

This includes:
§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or

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| F 801 | Continued From page 125<br>as required by state law.<br><br>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.<br>(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-<br>(A) A certified dietary manager; or<br>(B) A certified food service manager; or<br>(C) Has similar national certification for food service management and safety from a national certifying body; or<br>D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or<br>(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and<br>(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and<br>(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and | F 801 | F801 | |

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| F 801 | Continued From page 126<br>record review, the facility failed to designate a full-time qualified director of food and nutrition services or Dietary Manager (DM).<br><br>The findings included:<br><br>Review of the complete staffing list of employees provided by the facility on 2/17/25 revealed that there was a designated Dietary Manager (DM) at the facility.<br><br>During observations throughout the survey from 2/17/25 through 2/22/25, the facility DM was noted to be scheduled to work at the facility full-time and was observed as the staff member responsible for day-to-day operations in the kitchen.<br><br>During an interview on 2/18/25 at 12:04 PM, the Regional Dietary Manager said he came to the facility several times a week to support and oversee the facility Dietary Manager.<br><br>During an interview on 2/22/25 at 12:56 PM, the facility DM said he was in school to become a certified DM but was not certified yet, but the Regional DM was certified and managed the department while he was in school and would come several times a week.<br><br>During an interview on 2/22/25 at 6:34 PM, the Administrator confirmed that the DM did not have certification as a dietary manager and that he was in school and due to complete his studies in June. She said the Regional Dietary Manager managed the kitchen for the time being, coming to the facility several times a week. | F 801 | 1. At the time of the survey the center did not employ a certified dietary manager<br>2. A new certified dietary manager was hired and began working on 3/10/2025.<br>3. The administrator was educated by the Vice President of Operations on 3/18/2025 to ensure a qualified dietary individual is hired to meet the regulatory compliance and nutrition standards for the facility.<br>The administrator or designee will conduct weekly meetings x 12 with the dietary manager to ensure the nutritional needs of the residents and regulatory standards of the kitchen are maintained.<br>4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br>5. Date of completion: 3/25/2025 | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp | F 804 | | 3/25/25 |

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| F 804 | Continued From page 127<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, and staff, resident council, and resident interviews, and test tray, the facility failed to provide food that was palatable and served at an appetizing temperature for 10 of 13 residents (Residents #60, #85, #74, #70, #61, #5, #87, #62, #109, and #106) reviewed for food concerns.<br><br>The findings included:<br><br>a. The Resident Council minutes from December 2024 and January 2025 noted resident concerns with food palatability.<br><br>In a Resident Council interview on 2/18/25 at 10:30 AM, 8 out of 11 participants (Residents #74, #70, #61, #5, #87, #62, #109, and #106) expressed the food served was not palatable, that the food would be served cold and the meat was tough.<br><br>b. Resident #60's quarterly Minimum Data Set (MDS) dated 1/30/25 revealed the resident was cognitively intact and required supervision for eating. | F 804 | F804<br>1. The facility failed to ensure that food served to residents is palatable.<br>2. A new certified dietary manager was hired and began on 3/10/2025.<br>3. The dietary supervisor or designee will provide education to all dietary staff on food preparation techniques, flavor enhancements and presentation skills by 3/21/2025. Any dietary staff member who does not receive this education will be removed from the schedule until completed.<br>All new hire dietary staff will receive this education during orientation by the dietary manager.<br>Administrator or designee will complete test tray audits 5x week x 4 weeks, 3xweekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 to ensure food is palatable.<br><br>4. Results will be reported by the administrator to the quality assurance meeting x1 month for further resolution as needed. | |

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| F 804 | Continued From page 128<br>During an interview with Resident #60 on 2/17/25 at 9:23 AM, he reported the food did not taste good and that the meat that was served was dry. Resident #60 stated he ate his meals in his room.<br><br>c. Resident #85's admission MDS dated 1/23/25 revealed the resident was cognitively intact and required supervision for eating.<br><br>During an interview with Resident #85 on 2/16/25 at 3:33 PM, she reported the food did not taste good daily and she struggled to eat her meals. Resident #85 stated she ate her meals in her room.<br><br>d. Resident #74's quarterly MDS dated 11/17/24 revealed the resident was cognitively intact and was independent with eating.<br><br>Resident #74's diagnoses list included hemiplegia and hemiparesis (paralysis/weakness of one side of the body).<br><br>During an interview and observation with Resident #74 on 2/18/25 at 1:15 PM, he said he couldn't chew well and could only use one of his hands to perform tasks. He reported the food served for lunch that day, the baked chicken, was too hard to cut with one hand, was dry, and that he had dentures and the chicken was too tough to eat. During the interview, it was observed that Resident #74 attempted to use his fork to remove meat from the chicken breast but was unable to get more than a small piece.<br><br>A test tray was completed for the lunch meal on 2/18/25. The test tray was plated in the kitchen at 12:53 PM. At 12:57 PM, the test tray left the kitchen and was taken to the hall where Resident | F 804 | 5. Date of completion: 3/25/2025 | |

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| F 804 | Continued From page 129<br>#74 resided, the last hall served. At 1:16 PM, the last hall tray was served. The test tray consisted of a chicken breast, mashed potatoes and gravy, and baked beans. At 1:20 PM the surveyor and Dietary Manager (DM) tasted the chicken and the mashed potatoes with gravy. The chicken was tough and only a small piece of the breast was able to be pulled from the meat when the surveyor attempted to use only a fork. The mashed potatoes were covered in a thick gravy with a texture comparable to syrup that sat on top of the potatoes. The DM agreed the chicken was too tough to cut with only a fork and the gravy and mashed potatoes textures were not appetizing.<br><br>During an interview with the Dietary Manager on 2/18/25 at 1:25 PM, he said he knew several residents had concerns about food palatability and the dietary department was trying to address the concerns by altering the menus to better match the residents' preferences.<br><br>During an interview with the Administrator on 2/22/25 at 6:22 PM, she said preparing palatable food for the residents was a daily effort and she was aware some residents consistently complained about the food served. | F 804 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted | F 842 | | 3/25/25 |

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to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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| F 842 | Continued From page 131<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(h)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, and staff, Pharmacist, Corporate Nurse Consultant, and Physician interviews, the facility failed to maintain complete and accurate medical records for medication administration (Resident #50) and for documentation of nursing assessments and accurate physician notification time (Resident #34) for 2 of 46 residents whose medical records were reviewed.<br><br>Findings included:<br><br>1. Resident #50 was admitted to the facility on 7/8/2024 with diagnoses including depression.<br><br>Physician orders included Zoloft (brand name for Sertraline, an antidepressant medication) 50 milligrams (mg) one tablet a day for depression written on 1/30/2025 to start on 1/31/2025 at 9:00am and Sertraline (generic name for Zoloft) | F 842 | F842<br>1. Resident #50 medication administration record was corrected. Resident # 34 abnormal labs were reported to the provider.<br>2. Current residents are at risk<br>3. Director of Nursing or designee will educate current licensed nurses including agency licensed nurses in accuracy in medication transcription and notification of critical lab results to provider immediately at time of receiving. This education began 03/19/2025.<br>Any licensed nurse not receiving education will not be allowed to work until education is received.<br>Agency licensed nurses will receive education prior to the start of their shift.<br>New licensed nurses will receive education during the orientation process | |

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| F 842 | Continued From page 132<br>HCl 50 mg one time a day for depression written on 1/31/2025 to start on 2/1/2025 at 9:00am. The order for Zoloft was discontinued on 2/5/20205.<br><br>The February 2025 Medication Administration Record (MAR) for Resident #50 recorded Sertraline 50mg was scheduled for 9:00 am and administered on 2/1/2025 and 2/2/2025, and Zoloft 50 mg was scheduled for 9:00am and administered on 2/1/2025 and 2/2/2025. The MAR recorded Zoloft 50mg was not given on 2/3/2025 to 2/5/2025 and to see progress notes.<br><br>Nursing documentation dated 2/5/2025 at 1:22 pm by Nurse #4 recorded Zoloft 50mg one time a day for depression was a duplicate order. There was no nursing documentation in the progress notes recording why Zoloft was not administered on 2/3/2025 and 2/4/2025.<br><br>On 2/21/2025 at 2:04 pm in a phone interview with Nurse #4, she stated she recognized the medication Zoloft and Sertraline as the same medication and only administered Resident #50 one 50mg tablet each day. She stated Resident #50's February MAR looked as if she had administered Resident #50 both Sertraline 50mg and Zoloft 50mg on 2/1/2025 and 2/2/2025. She explained she thought she had marked one of the medications as not administered, and that Resident #50's February MAR was not accurate.<br><br>On 2/21/2025 at 4:55 pm in a phone interview with the Pharmacy Consultant #1, she explained the pharmacy only filled one of the Sertraline 50mg and Zoloft 50mg orders that were received and Resident #50's Zoloft medication card was delivered on 1/31/2025 at 10:32 pm to the facility. | F 842 | by the Director of Nursing or designee<br>4. Audits of the clinical order listing and the previous 24 hours of progress notes will be completed 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months. The director of nursing or designee will complete the audits and report any discrepancies during the morning clinical meeting<br>5. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br>6. Date of completion: 3/25/2025 | |

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On 2/22/2025 at 3:51 pm in an interview with the interim Director of Nursing (DON), she explained Nurse #4 recorded both Zoloft 50mg and Sertraline 50mg were administered on 2/1/2025 and 2/2/2025 on Resident #50's MAR when actually only Zoloft 50 mg was administered on 2/1/2025 and 2/2/2025. She stated Nurse #4 did not administer the medications twice as recorded on Resident #50's MAR.

On 2/22/2025 at 8:48 pm in an interview with the Vice President of Operations, she stated Nurse #4's documentation on Resident #50's MAR should show what medication the resident actually received.

2. Resident #34 was admitted to the facility on 12/13/2024 with diagnoses including diabetes and end stage renal disease.

Resident #34's laboratory test dated 2/22/2025 indicated the specimen was collected at 5:19 am.

Blood glucose monitoring for Resident #34 on 2/22/2025 revealed the following (normal blood glucose levels are considered to be between 70 milligrams per deciliter [mg/dL] to 100 mg/dL):
- 8:00 am the reading was 151
- 1:00 pm the reading was 111
- 8:00 pm the reading was 120

Resident #34's laboratory test recorded notification of critical laboratory results, glucose level of 928 and potassium level 6.1, to Nurse #8 on 2/22/2025 at 7:08 pm

On 2/22/2025 at 11:59 pm, Nurse #8 recorded Resident #34's blood glucose level as 120.

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Nursing documentation dated 2/23/2025 at 1:41 am by Nurse #8 recorded the physician was notified of the critical laboratory results and there were no new orders received.

The medical recorded included no documentation of a nursing assessment conducted for Resident #34 after notification of the critical lab results on 2/22/2025.

On 2/24/2025 at 11:12 am in a phone interview with Nurse #8, she stated Medication Aide #7 was assigned to Resident #34 on 2/22/2025 and as the nurse covering for Medication Aide #7, she notified the physician immediately at 7:10 pm on 2/22/2025 upon receiving notification of the critical labs and went to conduct an assessment on Resident #34. She described Resident #34 as alert, oriented, verbally joking with the staff and voiced no complaints. She stated Resident #34's vital signs were obtained and were normal. Nurse #8 stated she thought she had recorded Resident #34's vital signs and assessment Resident #34's medical record. She explained that she was assigned another group of residents and a medication cart on 2/22/20245. She explained that was why the physician notification was documented on 2/23/205 at 1:41 am instead of the actual time of notification 2/22/2025 at 7:10pm.

On 2/24/2025 at 12:42 pm in a phone interview with the Interim Director of Nursing (DON), she stated Nurse #8 reported she assessed Resident #34 on 2/22/2025 following the receipt of the critical lab values and there were no changes identified in Resident #34. The Interim DON stated there was documentation of Resident

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| F 842 | Continued From page 135<br>#34's vital signs on the end of the shift report sheet that was not part of Resident #34's medical record. The Interim DON also stated documentation of the time the physician was incorrect because notification of the physician actually was at 7:10 pm on 2/22/2025.<br><br>On 2/24/2025 at 2:04pm in a phone interview with Physician #1, he stated the facility notified him of the critical labs on 2/22/2025 at 7:10 pm. He stated due to the blood specimen for the laboratory test was obtained at 5:19 am on 2/22/2025, and Resident #34's blood glucose levels were recorded as less than 200 after the time of the collection of the blood. He indicated he felt the critical labs were inaccurate and the blood specimen had hemolyzed (destruction of red blood cells) when the laboratory test was performed on the blood specimen. The physician also stated there were no changes in Resident #34's condition reported on 2/22/2025.<br><br>On 2/24/2025 at 2:17pm in phone interview with Corporate Nurse Consultant #2, she stated there was not a nursing assessment recorded for 2/22/2025 for Resident #34's medical record and Nurse #8 should have documented the assessment performed on Resident #34 in the medical record. | F 842 | | |
| F 847 SS=D | Entering into Binding Arbitration Agreements<br>CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5)<br><br>§483.70(m) Binding Arbitration Agreements<br>If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. | F 847 | | 3/25/25 |

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| F 847 | Continued From page 136<br>§483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.<br><br>§483.70(m)(2) The facility must ensure that:<br>(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;<br>(ii) The resident or his or her representative acknowledges that he or she understands the agreement;<br><br>§483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.<br><br>§483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.<br><br>§483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, | F 847 | | |

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| F 847 | Continued From page 137<br>and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, and resident and staff interviews, the facility failed to explain the arbitration agreement to the resident prior to having them sign the agreement and to ensure they explicitly informed the resident that signing the agreement was not required as a condition of admission. This occurred for 2 of 3 residents (Resident#72, and Resident #109) reviewed for arbitration.<br><br>Findings included:<br><br>Review of the facility's "Arbitration Agreement," which was not dated, revealed documentation by signing the Arbitration Agreement the resident and/or the resident's representative acknowledged they had read and understood the agreement and that the agreement had been adequately explained to them in plain language.<br><br>a. Resident #72 was admitted to the facility on 6/5/24.<br><br>Review of Resident #72's arbitration agreement revealed the resident had signed the agreement on 6/5/24.<br><br>Resident #72's most recent Minimum Data Set (MDS) assessment dated 12/2/24, a quarterly assessment revealed she was cognitively intact.<br><br>An interview was conducted with Resident #72 on 2/18/25 at 4:50 PM. She stated she did not recall signing the arbitration agreement and if it had | F 847 | F847<br>1. Current residents have a current arbitration/declination signed in the patient□s electronic medical record.<br>2. An audit was conducted by the Regional Director of Census Development ( RDCD) for the current residents to ensure that all had arbitration or declinations signed. This is completed by 3/19/2025.<br>3. The admissions team was educated by the RDCD on how to utilize the approved script to explain the arbitration process to the resident or resident□s representative. Education completed on 3/19/2025.<br>Any member of the admission team not receiving education will not be allowed to work until education is received.<br>Any new member of the admission team will receive education during the orientation process by the RDCD.<br>New admissions will be audited by the RDCD or designee for the arbitration or declination form 5 x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2.<br>4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br>5. Date of completion: 3/25/2025 | |

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| F 847 | Continued From page 138 | F 847 | | |

been explained to her, she would not have signed the arbitration agreement. She further reported she remembered signing papers during the admission process, but there were so many papers to sign she did not understand them all.

b. Resident #109 was admitted to the facility on 6/20/24.

Review of Resident #109's arbitration agreement revealed the resident had signed the agreement on 6/24/25.

Resident #109's most recent Minimum Data Set (MDS) assessment dated 9/25/2024, a significant change assessment, revealed she was cognitively intact.

An interview was conducted with Resident #109 on 2/22/25 at 4:49 PM. She stated the forms she signed upon admission were not explained and she was not made aware it was not a condition of admission.

An interview was conducted with the Admissions Coordinator on 2/20/25 at 11:11 AM. The Admissions Coordinator reported she started at the facility on 8/5/24. She stated the former Admissions Coordinator would have been responsible for discussing the arbitration agreement with Resident #72 and Resident #109 upon admission prior to her starting. She stated she reads each section of the arbitration agreement and asked residents or their representatives to sign during the admissions process. She stated the facility had a "script" she reads during the explanation of the arbitration agreement. She reported if the resident or resident representative had questions about the

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| F 847 | Continued From page 139<br>arbitration agreement she would answer the questions for the resident. If needed she stated she would get further clarification about the admission agreement for the resident from the Administrator. The Admissions Coordinator stated the form had a place for the resident to initial if they understood each section of the admission agreement, including the arbitration agreement.<br><br>The former Admissions Coordinator was unavailable for an interview.<br><br>The Administrator was interviewed on 2/22/23 at 6:26 PM. The Administrator stated she expected the arbitration agreement to be explained to the resident and/or the resident representative in a language they can understand. She reported the current Admissions Coordinator has a script which ensures the agreement is explained fully. The Administrator stated she was not employed at the facility until 12/31/24. | F 847 | | |
| F 848 SS=D | Binding Arbitration Agreements<br>CFR(s): 483.70(m), 483.70(m)(2)(iii)(iv)(6)<br><br>§483.70(m) Binding Arbitration Agreements.<br>If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.<br><br>§483.70(m)(2) The facility must ensure that:<br>(iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and<br>(iv) The agreement provides for the selection of a venue that is convenient to both parties. | F 848 | | 3/25/25 |

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| F 848 | Continued From page 140<br>§483.70(n)( (6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with the facility Administrator, the facility failed to include the selection of a venue that was convenient to both parties in the Arbitration Agreement. This was for 1 of 3 (Resident #70) residents who were reviewed for entering into an Arbitration Agreement with the facility.<br><br>The findings included:<br><br>Resident #70 was admitted to the facility on 7/23/21.<br><br>A review of the Arbitration Agreement signed by Resident #70 on 9/12/24 revealed there was no information to address the selection of a venue convenient to both parties.<br><br>Resident #70's most recent Minimum Data Set (MDS) assessment dated 1/9/25 revealed he was cognitively intact.<br><br>The Administrator was interviewed on 2/22/23 at 6:26 PM. The Administrator stated she expected the arbitration agreement to contain all the required components. She reported the facility changed ownership in June 2024 and the required components were on the arbitration agreement currently in use. The Administrator stated she was not employed at the facility until | F 848 | F848<br><br>1. Current residents have a current arbitration/declination signed in the patient□s electronic medical record.<br>2. An audit was conducted by the Regional Director of Census Development ( RDCD) for the current residents to ensure that all had arbitration or declinations signed. This is completed by 3/19/2025.<br>New admissions agreement was completed for resident #70 An audit was conducted by the Regional Director of Census Development ( RDCD) for the current residents to ensure that all had arbitration or declinations signed. This is completed by 3/19/2025.<br>3. The admissions team was educated by the RDCD on how to utilize the approved script to explain the arbitration process to the resident or resident□s representative. Education completed on 3/19/2025.<br>Any member of the admission team not receiving education will not be allowed to work until education received.<br>Any new member of the admission team will receive education during the orientation process by the RDCD. | |

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| F 848 | Continued From page 141<br>12/31/24. | F 848 | Section D of the current arbitration agreement states the following:<br>The HCC shall be solely responsible for payment of the arbitration fee. The arbitration shall be conducted in a mutually agreeable venue, or, if the parties fail to agree, the city or county where the HCC is located. Each party agrees to bear their own attorneys fees and costs. The arbitrator(s) shall have authority to grant interim, injunctive, and final relief. In no instance shall any award for punitive damages exceed the amount authorized by N.C. Gen. Stat. ¿ 1D-25(b) as may be in effect at the time this Addendum to the Business Contract is signed, nor shall any award for noneconomic damages exceed the amount authorized by N.C. Gen. Stat. ¿ 90-21.19. The arbitrator(s) decision shall be binding on Resident and/or Responsible Party and the HCC and shall not be subject to further attack or appeal except as provided by the FAA<br>The current arbitration agreement will be utilized for all residents<br>4. Results will be reported by the administrator to the quality assurance meeting x3 months for further resolution as needed.<br><br>5. Date of completion: 3/25/2025 | |
| F 880 SS=J | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an | F 880 | | 3/25/25 |

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| F 880 | Continued From page 142 | F 880 | | |

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 143<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview, the facility failed to implement infection control policies and procedures when staff failed to: (1) disinfect an unlabeled glucometer (a blood glucose meter) that was shared between residents for 1 of 2 residents (Resident #35) observed to have a blood glucose level checked. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-registered disinfectant in accordance with the manufacturer's instructions for the glucometer potentially exposes residents | F 880 | F880<br>1. The facility failed to properly disinfect a shared glucose meter that was shared between two residents with an approved cleaning agent. The facility failed to use an approved cleaning agent for a glucose meter that was stored outside of the resident□s room. The facility failed to don and remove PPE when caring for a COVID-19-positive patient. The facility failed to review and document annual infection control practices. The facility failed to keep linen carts in hallways covered in 2 of 5 halls. | |

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| F 880 | Continued From page 144<br>to the spread of bloodborne infections. This occurred with six residents in the facility identified as having a diagnosis that included one or more bloodborne pathogens; (2) disinfect an individually assigned glucometer stored outside of the resident's room with an EPA-registered disinfectant in accordance with the manufacturer's instructions of the glucometer (Resident #32); (3) don necessary personal protective equipment (PPE) before entering a COVID isolation room and remove PPE before exiting the room; (4) evidence and documentation of annual review of infection control policies and procedures; and (5) cover the linen on linen carts located in the hallway to reduce the risk of accidental contamination.The uncovered linen carts were observed on 2 of 5 halls (300 and 400 halls). These deficient practices affected 3 of 127 residents residing in the facility (Residents #35, #32 and #230).<br><br>Immediate jeopardy began on 2/17/2025 at 5:50 am when Nurse #1 was observed performing a blood glucose test on Resident #35 using shared glucometer and not disinfecting the glucometer before and after performing the blood glucose test. Immediate jeopardy was removed on 2/19/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not immediate jeopardy) for findings #2, #3, #4, and #5 for the facility's completion of employee and agency nursing staff training with blood glucose monitoring to ensure effective interventions were implemented.<br><br>The findings included: | F 880 | 2. Current residents who require finger stick blood sugars received their own individual glucometers, and they were labeled and placed in an individual container. The was completed by the Director of Nursing and the Assistant Director of Nursing on 2/18/2025. Education was completed on 2/18/2025 by the Director of Nursing and Assistant Director of Nursing on the appropriate cleaning agent to be used. Rooms with transmission-based precautions were audited to ensure PPE is available and appropriate signage is available. This was completed by the Director of Nursing on 3/19/2025, An audit was completed by the Director of Nursing to ensure all linen carts had covers and covers were in use. This was completed on 3/19/2025.<br>3. Education was started by the Director of Nursing on 2/18/2025 to current licensed nursing staff, including agency staff, on proper procedure for cleaning glucometers and for proper storage of glucometers. Employees not receiving this education will not be allowed to work until the education is received. The Director of Nursing will track the education to ensure that current staff have received. Education includes each resident who receives a finger stick blood sugar will have an individual glucometer that is labeled with their name and stored in an individual container inside the med cart. Education also includes the proper cleaning technique as recommended by the manufacturer guidelines. The cleaning product will be kept on each medication | |

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| F 880 | Continued From page 145<br><br>1. The glucometer manufacturer's operator manual dated 2016 provided instructions for cleaning and disinfecting the glucometer used at the facility. It stated, in part: all parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals. The meter should be disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. The manufacturer's instructions listed approved EPA registered wipes for cleaning and disinfecting the glucometer and stated other EPA registered wipes may be used for disinfecting the glucometer used by the facility.<br><br>The cleaning and disinfecting step-by-step instructions included, in part:<br>Step 3: inspect for blood, debris, dust or lint anywhere on the meter. Blood and bodily fluids must be thoroughly cleaned from the surface of the meter.<br>Step 4: Clean the meter using a moist lint-free cloth dampened with a mild detergent and wiping all external areas of the meter including the front and back surfaces until visibly clean.<br>Step 5: Disinfect the meter, cleaning the surface with an approved disinfectant wipe and wiping all external areas of the meter including front and back surface until visibly wet.<br><br>The instructions for the EPA approved disinfectant wipes dated 2023 stated the minute wipe was an effective virucide, bactericide, tuberculocide and fungicide on hard non-porous | F 880 | cart. The Director of Nursing or charge nurse will check the med carts daily to ensure that the cleaning product is present on each med cart. The Director of Nursing educated the charge nurses on 2/18/2025. The Director of Nursing was educated on this process by the Administrator on 2/18/2025.<br>Current Licensed Nurses will complete a skills return demonstration on glucometer cleaning and storage. This will be completed by the Director of Nursing. Any licensed nurse will not be allowed to work until return demonstration has been completed. The Director of Nursing will track the education to ensure that current staff have received.<br>The Director of Nursing or charge nurse is responsible for ensuring new admissions who require finger stick blood sugars are provided with their own individual glucometer that is labeled with their name and stored in an individual container. The Director of Nursing was educated on this process by the Administrator on 2/18/2025. The charge nurses are educated on this process by the Director of Nursing on 02/18/2025.<br>New licensed nurses will receive this education and verify competencies during the orientation process by the Director of Nursing or charge nurse. Agency nurses will receive this education and competencies prior to the start of their shift. The charge nurses were educated on this responsibility by the Director of Nursing on 02/18/2025. The Director of Nursing will assign the charge nurse to complete this task when needed. | |

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| F 880 | Continued From page 146<br>surfaces. When using the disinfectant wipe, apply the wipe to a hard, non-porous surface (the glucometer), allowing it to remain wet for one minute and allow the surface to air dry.<br><br>On 2/17/2025 at 5:50 am in preparation to check Resident #35's blood glucose, Nurse #1 was observed searching for Resident #35's glucometer. Nurse #1 stated each resident had their individually assigned glucometer to check blood glucose levels. Nurse #1 was observed opening the top drawer of the 100-hall medication cart flipping three glucometer pouches labeled with Resident #66's, Resident #33's and Resident # 93's name and room number upward toward Nurse #1. Nurse #1 was observed locking the 100-hall medication cart and walking to the 200-hall medication cart before returning to the 100-hall medication cart and reopening the top drawer. Nurse #1 reflipped Resident #66's, Resident #33's and Resident # 93's labeled glucometer pouches upward toward her and picked up Resident #33's glucometer pouch. There was an unlabeled glucometer not in a labeled glucometer pouch observed underneath Resident #33's glucometer pouch. Nurse #1 stated the unlabeled glucometer was Resident #35's glucometer and was observed not disinfecting the glucometer before performing a blood glucose test on Resident #35 on 2/17/2025 at 5:56 am. Nurse #1 was observed returning the used unlabeled glucometer to the top drawer of the 100-hall medication cart without disinfecting the glucometer.<br><br>On 2/17/2025 at 6:00 am in an interview with Nurse #1, she stated Resident #35 did not have a labeled glucometer pouch and there were two glucometers in Resident #66's pouch earlier, and | F 880 | Education provided to current staff including agency staff regarding transmission-based precautions and the appropriate PPE to use while caring for a COVID positive resident. This education by the Director of Nursing began on 3/19/2025.<br>Any staff member not receiving education will not be allowed to work until education received.<br>Agency staff will receive education prior to the start of their shift by the Director of Nursing or designee.<br>New staff will receive education during the orientation process.<br>Education was provided to current staff including agency staff regarding keeping linen carts covered at all times.<br>Any staff not receiving education will not be allowed to work until education received. Agency staff will receive education prior to the beginning of their shift.<br>New staff will be educated by the Director of Nursing during the orientation process.<br>Director of Nursing or designee will audit 10 resident glucometer checks weekly x 4 weeks, then 5 x 4 weeks, then 3 weekly x 4 weeks. then 3 monthly x 2.<br>The Director of Nursing or designee will audit the med carts for cleaning solution 3x weekly x 4 weeks, then 2 weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2<br>The Director of Nursing will audit the residents requiring glucometers to ensure glucometers present 3x weekly x 4 weeks, then 2x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 | |

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| F 880 | Continued From page 147<br>the glucometer that was not found in a glucometer pouch, must have fallen out of the unzipped glucometer pouch of Resident #66. The glucometer in Resident #66's pouch was observed unlabeled. Nurse #1 stated she did not know which glucometer was Resident #35's and grabbed the unlabeled glucometer that was not in a labeled glucometer pouch to perform Resident #35's blood glucose. Nurse #1 stated the reason she did not disinfect the glucometer before performing the blood glucose was because the staff member who used the glucometer before she used it should have disinfected the glucometer. Nurse #1 stated she did not think about disinfecting the glucometer after performing the blood glucose test. Nurse #1 was observed removing an alcohol pad from the top drawer of the 100-hall medication cart and wiping the unlabeled glucometer without an resident identified glucometer pouch with the alcohol pad and returning the unlabeled glucometer to the top drawer of the 100-hall medication cart. She stated she always disinfected glucometers with alcohol pads and Resident #35 was the only blood glucose monitoring she had to perform.<br><br>On 2/18/2025 at 10:08 am in an interview with Nurse #2 she stated due to Medication Aide #5 being assigned to the 100-hall medication cart on 2/16/2025 for the 7:00 am to 7:00 pm shift, she performed Resident #35's blood glucose monitoring. She stated Resident #35 did not have an individually assigned glucometer and when performing Resident #35's blood glucose monitoring, the unlabeled glucometer that was not stored in a labeled pouch with resident's name and room number on the 100-hall medication cart was used for Resident #35 and Resident #31, who also did not have an | F 880 | Director of Nursing or designee to audit 10 transmission-based rooms for appropriate PPE use weekly x 4 weeks, then 5 weekly x 4 weeks, then 3 weekly x 4 weeks, then weekly x 8 weeks.<br>Director of Nursing or designee will audit linen carts for coverings 5x weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly x 4 weeks then monthly x 2.<br>4. Results will be reported by the Director of Nursing to the quality assurance meeting x3 months for further resolution as needed.<br><br>5. Date of completion: 3/25/2025 | |

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individually assigned glucometer. She stated she used disinfectant wipes on the 100-hall medication cart to disinfect the unlabeled glucometer after each use.

On 2/18/2025 at 10:42 am in a follow up phone interview with Nurse #1, she stated she thought the unlabeled glucometer that was not in a pouch labeled with a resident's name and room number on the 100-hall medication cart was Resident #35's glucometer on 2/17/2025 when performing the blood glucose monitoring. She stated Resident #31 also received blood glucose monitoring and did not have an individually assigned glucometer, and she had forgotten Resident #35 and Resident #31 shared the unlabeled glucometer not in a labeled pouch. Nurse #1 stated she was trained on how to use and disinfect a glucometer with employment orientation and was unable to recall the instructions on how to use the disinfectant wipes at the facility. She reported there were no disinfectant wipes on the 100-hall medication cart to clean the glucometer on the morning of 2/17/2025.

On 2/18/2025 at 10:30 am in an interview with the Central Supply, she reported there were no disinfectant wipes in the central supply room. She stated she restocked the 100-hall medication cart with disinfectant wipes on the morning of 2/17/2025 upon reporting to work for the 7:00am to 3:00pm shift.

On 2/17/2025 at 6:50 am in an interview with the Director of Nursing (DON), she stated the facility did not have an individually assigned glucometer for every resident receiving blood glucose monitoring, and there were glucometers on the

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medication carts that were shared between residents. The DON stated Nurse #1 should have disinfected the glucometer that was shared between the residents with the facility's EPA-disinfectant wipes and allow the glucometer to dry for two minutes before storing in resident's labeled glucometer pouch.

The Regional Director of Clinical Services indicated via email on 2/18/2025 at 5:26 pm that there were six current residents in the facility identified as having a diagnosis that included one or more bloodborne pathogens.

The Administrator was informed of the immediate jeopardy (IJ) on 2/18/2025 at 2:00 pm.

The facility provided the following plan for IJ removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
Nurse #1 failed to ensure an unlabeled / unidentified glucometer that was shared between Resident #35 and Resident #31 on the 100-hall medication cart was cleaned and disinfected prior to and after use. (Resident #35). Nurse #1 thought the glucometer was individually assigned to Resident #35 and had forgotten that the unlabeled / unidentified glucometer was also used on Resident #31.

Nurse #1 indicated the glucometer used for Resident #35 was individually assigned. She stated she did not think about cleaning and disinfecting the unlabeled / unidentified glucometer after performing Resident #35's blood glucose and stated she always cleaned residents'

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glucometer with alcohol wipes. The Director of Nursing stated the facility did not have a glucometer for every resident receiving blood glucose monitoring and some of the glucometers on the medication carts were shared between residents. The DON stated glucometers were to be cleansed with an approved disinfectant.

Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an EPA-registered disinfectant in accordance with the manufacturer's instructions to disinfect a shared glucometer potentially exposes residents to the spread of blood borne infections. There are six current residents within the facility identified as having a diagnosis which included one or more blood borne pathogens.

The following immediate actions were taken for affected residents:
The facility Medical Director was notified by the Administrator of the facility on 2/18/2025 of the deficient practice for Resident #35 and of the new process of each resident having their own designated glucometer. He is in agreement with the current process for cleaning and storage of glucometers with no further recommendation. No recommendations were provided for Resident #35.

The local county Health Department Communicable Disease Coordinator was notified by the facility Administrator on 2/18/2025 with no further recommendations at this time.

Current residents that receive finger stick blood sugar checks are at risk. Forty residents require

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FSBS and all forty have been provided their individual glucometer. The Assistant Director of Nursing completed an audit on 2/18/2025.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
Current residents who require finger stick blood sugars received their own individual glucometers and they were labeled and placed in an individual container. The was completed by the Director of Nursing and the Assistant Director of Nursing on 2/18/2025.

Education was started by the Director of Nursing on 2/18/2025 to current licensed nursing staff, including agency staff, on proper procedure for cleaning/disinfecting glucometers and for proper storage of glucometers. Employees not receiving this education will not be allowed to work until the education is received. The Director of Nursing will track the education to ensure that current staff have received.

Education includes each resident who receives a finger stick blood sugar will have an individual glucometer that is labeled with their name and stored in an individual container inside the med cart. Education also includes the proper cleaning technique as recommended by the manufacturer guidelines. The cleaning product will be kept on each medication cart. The Director of Nursing or charge nurse will check the med carts daily to ensure that the cleaning product is present on each med cart. The Director of Nursing educated the charge nurses on 2/18/2025. The Director of Nursing was educated on this process by the Administrator on 2/18/2025.

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| F 880 | Continued From page 152<br><br>The Director of Nursing or charge nurse is responsible for ensuring new admissions who require finger stick blood sugars are provided with their own individual glucometer that is labeled with their name and stored in an individual container. The Director of Nursing was educated on this process by the Administrator on 2/18/2025. The charge nurses are educated on this process by the Director of Nursing on 02/18/2025.<br><br>New licensed nurses will receive this education during the orientation process by the Director of Nursing or charge nurse on 02/18/2025. Agency nurses will receive this education prior to the start of their shift. The charge nurses were educated on this process on 02/18/2025 by the Director of Nurse. The Director of Nursing will assign the charge nurse to complete this task when needed.<br><br>Immediate Jeopardy Removal Date: 2/19/2025<br>The facility's credible allegation of immediate jeopardy removal was validated on 2/22/25.<br>A phone interview with the medical director on 2/18/2025 validated the facility had notified the physician of the deficient practice and the facility was implementing new practices that included an individual glucometer per resident and educating the nursing staff on how to disinfect the glucometer after use on a resident. Observation of the 43 residents' (40 plus 3 admissions since 2/18/2025) individually assigned glucometers who currently resided in the facility on 2/22/2025 validated each resident receiving blood glucose monitoring had an individually assigned glucometer in a glucometer pouch labeled with their name and room number. Interviews with licensed nursing staff on each hallway and on all | F 880 | | |

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shifts validated in-service training was conducted in regard to the use of individually assigned glucometers for resident blood glucose monitoring and the infection control practices for the disinfection of glucometers. All licensed nursing staff who were interviewed reported they had received the required in-service training on 2/18/2025 or prior to beginning their next assigned shift after 2/18/2025. The educational in-services stressed using individually assigned glucometers for each resident requiring blood glucose monitoring and storing each individual assigned glucometer in an individually labeled glucometer pouch with resident's name and room number. The in-service training also included a review of the manufacturer's instructions for the facility's glucometers and disinfectant wipes related to disinfection of the glucometer and completion of a returned demonstration of the proper procedure for effective glucometer disinfection. Nurse observation in conducting a blood glucose check and subsequent glucometer disinfection completed the task without difficulty. Individually assigned resident glucometers were observed stored on the medication carts in closed labeled pouches with resident's name and room number. Each medication cart was observed with a canister of EPA disinfectant wipes. There was an unused unlabeled new glucometer observed on each medication cart that licensed nursing staff validated through interviews the new unused glucometers were available for new admissions, replacement of a resident's individually assigned glucometer or in an emergency as needed. To prevent the likelihood of a new glucometer used as a shared glucometer, the facility removed the new, unused glucometers from each medication cart and relocated the storage of the new unused glucometer into the medication storage rooms on

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each unit. There were no further concerns identified during either the interviews or observations.

The immediate jeopardy removal date of 2/19/2025 was validated.

2. The manufacturer's operator manual revised 10/2019 for Resident #32's assigned glucometer provided instructions for cleaning and disinfecting the glucometer used at the facility. It stated, in part: to minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed after each use. The manufacturer's instructions listed approved EPA registered wipes for cleaning and disinfecting the glucometer and stated other EPA registered wipes may be used for disinfecting the glucometer used by the facility.

The cleaning and disinfecting procedure for Resident #32's individually assigned glucometer included in part:
Step 5: using one EPA disinfectant towelette to wipe the entire surface of the glucometer horizontally and vertically to remove bloodborne pathogens and
Step 6: Treated surface must remain wet for the recommended contact time. Do not wrap the meter in a towelette.

The instructions for the EPA approved disinfectant wipes dated 2023 stated the minute wipe was an effective virucide, bactericide, tuberculocide and fungicide on hard non-porous surfaces. When using the disinfectant wipe, apply the wipe to a hard, non-porous surface (the glucometer), allowing it to remain wet for one minute and allow the surface to air dry.

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On 2/18/2025 at 7:51 am, Medication Aide #1 (agency) was observed performing blood glucose monitoring using an individually assigned glucometer for Resident #32. After obtaining a blood glucose level, Medication Aide #1 was observed cleaning Resident #32's individually assigned glucometer with alcohol wipes.

On 2/18/2025 at 7:57am in an interview with Medication Aide #1, she explained Resident #32's glucometer needed to be disinfected after use and she cleaned the glucometer with an alcohol pad because she did not have any disinfectant wipes on the 300-hall medication cart.

On 2/18/2025 at 10:25 am in a follow up interview with Medication Aide #1, she stated she received training less than a month ago at the facility on using disinfectant wipes to clean glucometers after use. She stated there were disinfectant wipes on the 300-hall medication cart, and she did not know the disinfectant wipes were on the 300-hall medication cart because she had not checked the 300-hall medication cart.

On 2/18/2025 at 5:10 pm in an interview with the Director of Nursing, she stated Resident #32's individually assigned glucometer needed to be disinfected after each use using a disinfectant wipe.

3. The facility's policy for "COVID-19" dated 10/24/2024 stated in part: to implement Special Droplet-Contract Precautions until patient meets the Center of Disease Control and Prevention criteria for discontinuation of transmission -based precautions. The facility's policy "Transmission Based Precautions-General

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Practice" dated 12/1/2021 stated in part: to maintain transmission based precautions before entering the patient's room and fundamental protective measures: hand washing, use of mask, eye protection, gowns and gloves. Supplies are kept near the entrance and large trash can for general trash placed inside the room. When donning the protective attire: wash hands, put on gown, apply mask, put on goggles or face shield if required. Removing of protective attire in the patient's room in the trach can: gloves, goggles or face shield, gown and mask.

On 2/17/2025 at 4:20 am, Nurse #5 was observed applying an isolation gown, gloves and N-95 mask before entering Resident #230' room.

On 2/17/2025 at 4:22 am, there was a droplet precautions sign observed posted on Resident #230's door. A three-drawer container was observed outside Resident #230's door and contained gowns, face mask, N-95 mask, gloves and eye protection. Nurse #5 was observed inside Resident #230's room preparing to obtain Resident #230 vital signs not wearing eye protection.

On 2/17/2025 at 4:27 am, Nurse #5 was observed exiting Resident #230's room into the hallway and removing the isolation gown, gloves and N-95 and discarding the personal protective equipment (PPE) into one of two large trash cans observed located in the hallway outside of Resident #230's room.

On 2/17/2025 at 4:29 am in an interview with Nurse #5, she stated Resident #230 was on isolation for COVID-19 that required contact and droplet precautions. She stated she did not place

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the droplet precautions signage on Resident #230's door. She stated eye protection was available to wear and stated she did not need to wear eye protection to enter Resident #230's room because she was fully vaccinated against COVID-19. She explained she removed the PPE (gown, gloves and N-95 mask) after exiting Resident #230's room because of the large grey trash cans were located outside Resident #230's room and she didn't want to contaminate herself inside the room. Nurse #5 stated she was an agency nurse and had received infection control training from the agency. She stated she had worked at the facility for one week and had not received COVID-19 and PPE training from the facility.

On 2/18/2025 at 5:28 pm in an interview with Unit Manager #1, she stated she had made an error and placed the wrong isolation signage for droplet precautions on Resident #230's door. She stated the droplet precautions signage did not include the use of a N-95 mask, gown or eye protection to enter Resident #230 room and the posted signage on Resident #230's door should have been special droplet and contact precautions. She stated the required PPE (gown, gloves, N-95 mask and face shield for eye protection) were placed outside Resident #230's door for the staff to use and the trash cans should have been inside Resident #230's room for Nurse #5 to remove the PPE inside Resident #230's room before exiting the room.

On 2/18/2025 at 5:10 pm in an interview with the Director of Nursing (DON), she stated Resident #230 was admitted with COVID-19 and she did not know exactly which isolation signage was to be posted on Resident #230's door. She

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explained Unit Manager #1 was responsible for posting the isolation precaution signage on Resident #230 door. The DON stated Nurse #5 should have worn eye protection before entering Resident #230's room to provide resident care and should have removed the PPE before exiting Resident #230's room. The DON reported that when she started five weeks ago at the facility she was informed that infection control was her responsibility also, and she had not performed any tasks (training, reports) related to infection control.

4. Review of the facility's Infection Prevention and Control Policies and Procedures revealed an Infection Prevention and Control Manual with an effective date of 2/6/20 with no evidence of annual review.

During an interview with the Director of Nursing (DON) #1 on 2/17/25 at 5:06 pm, she stated she was responsible for the Infection Prevention and Control program. The DON #1 further stated she had been in the DON position for 5 weeks and had been unable to review the Infection Prevention and Control Policies.

In an interview with Corporate Nurse Consultant #1 on 2/22/25 at 5:00 pm, she stated the facility was currently working on their Infection Prevention and Control program. The Corporate Nurse Consultant #1 did not have documentation of annual review and signed Infection Prevention and Control policies and procedures.

5. Review of the facility's Infection Prevention and Control policy and procedures for linen read, "Clean towels will be kept covered and available

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for individual use."

The clean linen cart on the 300 hall was observed on 2/17/25 at 3:28 pm with the front cover pulled up and resting on the top of the mesh covered plastic pipe line cart.

During an interview with Unit Manager #1 on 2/17/25 at 3:30 pm, she stated all linen carts should be covered for infection control purposes. Unit Manager #1 placed the covering correctly on the linen cart.

A continuous observation was made on 2/18/25 from 9:03 am until 9:10 am of the linen cart on the 400 hall. The front cover was pulled up and was resting on the top of the mesh covered plastic pipe linen cart. Clean gowns, towels, wash clothes, and blankets were observed on the cart. The maintenance staff was observed walking by pulling furniture at 9:05 am and Physical Therapy staff was observed walking by at 9:06 am. A NA was observed walking by with bagged trash in hand at 9:09 am. Another NA with a plate and cup in hand was observed walking by at 9:09 am. The linen cart front covered was closed by a NA at 9:10 am.

During an interview on 2/28/25 at 9:35 am with NA #5, she stated the linen carts should be covered after retrieving the items needed for resident care for infection control prevention.

The clean linen cart on the 300 hall was observed for a second time on 2/21/25 at 12:29 pm with the front covering on top of the linen cart.

During an interview with Nursing Assistant (NA) #3 on 2/21/25 at 12:39 pm, she stated the linen

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| F 880 | Continued From page 160<br>carts are supposed to be covered when not in use due to infection control prevention. She immediately placed the covering on the linen cart correctly.<br><br>During an interview with the Housekeeping Manager on 2/18/25 at 3:00 pm, she indicated the linen carts on the hall ways held clean gowns, towels, wash clothes, and blankets for the residents. She further indicated the linen carts should be covered when not in use by the staff.<br><br>In an interview with the Administrator and Corporate Nurse Consultant #1 on 2/22/25 at 5:00 pm, the Administrator stated she expected the linen carts to be covered when the nursing staff were not using them. The Corporate Nurse Consultant #1 indicated they were working on the infection control program at the facility. | F 880 | | |
| F 881 SS=F | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility policy review, record review and staff interviews the facility failed to implement an antibiotic stewardship program to monitor antibiotic usage in the facility. This practice had the potential to affect 127 of 127 residents in the | F 881 | F881<br>1. The facility failed to implement an effective antibiotic stewardship program in one or more areas, resulting in the potential for infection transmission. | 3/25/25 |

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| F 881 | Continued From page 161<br>facility.<br><br>The findings included:<br><br>Review of the facility's policy titled, Antibiotic Stewardship Program, effective date 10/24/22 revealed the following: "The Antibiotic Stewardship Program is designed to promote the appropriate use of antibiotics, monitoring, and management of clinical antimicrobial outcomes, reduce antibiotic resistance, to the extent possible."<br><br>During an interview with the Director of Nursing (DON) #1 on 2/17/25 at 5:06 pm, she stated she was responsible for the Infection Prevention and Control program. The DON #1 further stated she had been in the DON position for 5 weeks and there was not an Antibiotic Stewardship Program, and she had not had the time to start one. When asked had the facility been monitoring and tracking infections within the facility, she replied no. She indicated she had just learned there was a software program for Antibiotic Stewardship on the computer, but she had not used it.<br><br>In an interview with Corporate Nurse Consultant #1 on 2/22/25 at 5:00 pm, she stated the facility was currently working on their infection control program which included the Antibiotic Stewardship Program. The department heads in their morning meetings had discussions about the residents and the antibiotics used in the facility. She indicated an infection control program was on their computer and worked as long nursing input the information concerning resident antibiotic use and infections within the facility. The Corporate Nurse Consultant #1 did not have documentation on the tracking or trending of | F 881 | 2. Current residents are affected by this practice.<br>3. Education completed by the Director of Nursing to the nursing leadership team on antibiotic stewardship and surveillance. This was completed on 3/25/2025.<br>Any new nursing leadership member not receiving education will not be allowed to work until education received.<br>Any new nursing leadership member will receive education during the orientation process by the Director of Nursing or designated Infection preventionist.<br>An audit of progress notes and order listings will be completed by the nursing leadership team to ensure that new antibiotics have been identified infection screening and antibiotic timeouts are completed. This will happen 5 x weekly x 4 weeks, then 3 x weekly x 4 weeks, then 2x weekly x 4 weeks, then weekly x 8 weeks.<br>4. Results will be reported by the Director of nursing or Infection preventionist to the quality assurance meeting x3 month for further resolution as needed.<br><br>5. Date of completion: 3/25/2025 | |

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| F 881 | Continued From page 162<br>infection within the facility. | F 881 | | |
| F 914 SS=D | Bedrooms Assure Full Visual Privacy<br>CFR(s): 483.90(e)(1)(iv)(v)<br><br>§483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;<br><br>§483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and interviews with resident and staff, the facility failed to ensure full visual privacy was available for 1 of 5 rooms (Room #318) reviewed for the privacy curtain.<br><br>The findings were:<br><br>An observation on 2/16/25 at 10:54 AM of Room #318 revealed that the privacy curtain would not close to provide full visual privacy to the resident. There was approximately 24 inches of the head of the bed and the resident visible from the door.<br><br>An observation on 2/22/25 at 1:12 PM revealed the privacy curtain did not close fully around the bed. Upon closer inspection it was noted the curtain connectors got stuck where the two tracks were joined since the curtain connectors did not line up with the second track. There was approximately 24 inches of the head of the bed and the resident visible from the door. | F 914 | F914<br>1. Room 318 privacy curtain was replaced to ensure full privacy. This will be completed by 3/25/2025<br>2. Audit was completed of current privacy curtains to ensure full privacy was in place. Audit was completed by the administrator or designee on 3/19/2025. Any privacy curtains not in place will be by 3/25/2025.<br>3. The administrator educated the current housekeeping department and the current maintenance department on privacy curtain length and the necessity to maintain privacy. This began on 3/19/2025.<br>Any housekeeping or maintenance staff not receiving education will not be allowed to work until education is received.<br>Any new employee will receive education during the orientation process.<br>4. Administrator or designee will audit 20 rooms weekly x 4 weeks, then 10 rooms | 3/25/25 |

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| F 914 | Continued From page 163<br>In an interview on 2/22/25 at 1:13 PM, the resident who resided Room #318 said the privacy curtain had not been able to be completely pulled closed for a "long time", but was unable to remember how long. The resident did not remember telling anyone about the curtain but said the staff knew.<br><br>In an interview on 2/22/25 at 3:31 PM, the Activity Director said when something in a resident's room was broken or didn't work, the staff were responsible for notifying maintenance through the maintenance application. She said she had not realized the privacy curtain was not closing.<br><br>Review of the facility Maintenance Logs for 2024 and 2025 did not document the privacy curtain in Room #318 needed to be fixed.<br><br>Attempts to interview the former Maintenance Director were unsuccessful.<br><br>In an interview on 2/22/25 at 5:31 PM, the Interim Director of Nursing said the privacy curtain in Room #318 should have been reported for repair so that complete visual privacy could have been provided.<br><br>In an interview on 2/22/25 at 6:34 PM, the Administrator said she was not aware the privacy curtain in Room #318 needed to be fixed and was not sure if the former Maintenance Director was aware. | F 914 | weekly x 4 weeks, then 5 rooms weekly x4 weeks, then 5 rooms monthly x 2 to ensure privacy curtains are providing complete privacy.<br>5. Results will be reported by the Administrator to the quality assurance meeting x1 month for further resolution as needed.<br>6. Date of completion: 3/25/2025 | |
| F 940 SS=E | Training Requirements<br>CFR(s): 483.95<br><br>§483.95 Training Requirements<br>A facility must develop, implement, and maintain | F 940 | | 3/25/25 |

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| F 940 | Continued From page 164<br>an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to-<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to implement an effective training program to ensure staff received required training and to maintain documented evidence of trainings for 4 of 4 Nursing Assistants (NA #2, NA #8, NA #9, and NA #11). This practice had the potential to affect all residents.<br><br>The findings included:<br><br>A review of the 2024 annual education records provided by the facility revealed no documented evidence that communication, resident rights, compliance and ethics, behavioral health, infection control training on policies and procedures, and QAPI training were conducted for the staff.<br><br>a. NA #9's personnel file revealed no documentation of communication, resident rights, compliance and ethics, behavioral health, infection control or QAPI training in 2024 through present.<br><br>A phone interview was conducted on 2/21/25 at 3:46 pm with NA #9. She stated she had worked at the facility approximately 4 years. NA #9 stated she received dementia and abuse training on 9/24/24. She did not recall training related to | F 940 | F940<br>1. The facility failed to implement an effective training program to ensure staff received the required training.<br>2. The human resources manager conducted an immediate audit of all current staff to assess completion of required training for calendar year 2025. This was completed on 3/19/2025.<br>Current staff to have all required training for 2025 completed using the Relias electronic training system by 3/25/2025<br>All current agency staff will complete orientation training acknowledgement by 3/25/2025<br>The facility hired a staff development coordinator on 2/18/2025 to oversee the mandatory training program of the facility. They began working on 3/4/2025.<br>The facility established a 12-month calendar for required training through Relias electronic training system on 3/19/2025.<br>3. Education completed to current employees by the Director of Nursing or designee on following the Relias electronic training learning system calendar on 3/25/2025 and completing 2025 required education by 3/25/2025. | |

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| F 940 | Continued From page 165<br>communication, resident rights, compliance and ethics, behavioral health, and infection control policies and procedures or QAPI training being done in 2024 through present.<br><br>b. NA #11's personnel file revealed no documentation of communication, resident rights, compliance and ethics, behavioral health, infection control and QAPI training in 2024 through present.<br><br>During a phone interview with NA #11 on 2/21/25 at 4:00 pm, he stated he received dementia and abuse training in September but could not recall the date. He further stated he had not received any training in communication, resident rights, compliance and ethics, behavioral health, and infection control policies and procedures or QAPI training in 2024 through present.<br><br>c. NA #2's personnel file revealed no documentation of communication, resident rights, compliance and ethics, behavioral health, and infection control or QAPI training in 2024 through present.<br><br>A phone interview was conducted on 2/21/25 at 11:35 am with NA #2. She stated she had received dementia care and abuse training in September 2024 but does not recall any training communication, resident rights, compliance and ethics, behavioral health, and on infection control policies and procedures or QAPI training in 2024 through present.<br><br>d. NA #8's personnel file revealed no | F 940 | Any employee not up to date on required education will not be allowed to work.<br>Agency staff will receive orientation training acknowledgment at the beginning of their shift.<br>Any new employee hired will receive education during the orientation process.<br>A Weekly audit will be completed by the Staff Development Coordinator or designee on the Relias learning education with staff completion. This audit will be completed weekly x 12 weeks, then monthly x 2. The Director of Nursing will audit the Staff Development Coordinator□s agency files weekly x 12 weeks, then monthly x 2 for newly scheduled agency staff to ensure they have completed the orientation training acknowledgment.<br>4. Results will be reported by the Staff Development Coordinator or Director of Nursing to the quality assurance meeting x3 months for further resolution as needed<br><br>5. Date of Completion 3/25/2025 | |

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documentation of communication, resident rights, compliance and ethics, behavioral health, and infection control and QAPI training in 2024 through present.

An attempt was made to interview NA #8 on 2/18/25 at 5:00 am but she was unavailable for interview.

The Director of Nursing (DON) #1 was interviewed on 2/17/25 at 5:06 pm. She stated she had been with the facility since December, and she was unable to do any educational training

During an interview with the Corporate Nurse Consultant #1 on 2/22/25 at 5:00 pm, she thought the NA training had been completed and was still looking for documentation. No other documentation for education was provided.

In an interview with the Administrator on 2/22/25 at 5:00 pm, she stated the facility did not currently have a Staff Development Coordinator nurse and the staff educational training was the responsibility of the Director of Nursing (DON) #1.