STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT GASTONIA	969 COX ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/07/25 through 04/10/25. Additional interviews were conducted on 04/14/25. The survey team returned onsite on 04/29/25 to investigate a new complaint allegation. The credible allegation was validated on 05/05/25 therefore, the exit date was changed to 05/05/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 9F8M11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 04/07/25 through 04/10/25. Additional interviews were conducted on 04/14/25. The survey team returned onsite on 04/29/25 to conduct a new complaint allegation. The credible allegation was validated on 05/05/25 therefore, the exit date was changed to 05/05/25. Event ID# 9F8M11. The following intakes were investigated: NC00224880, NC00226490, NC00223855, NC00223296, NC00221844, NC00222084, NC00219600, NC00227207, NC00225933, NC00225932, NC00225390, NC00224446, NC00224497, NC00224400, NC00222803, NC00222056, NC00227780, NC00225864, NC00221354, NC00220042, NC00226976, NC00226572, NC00225106, NC00224831, NC00223399, NC00221452, NC00220542, NC00226759, NC00225695, NC00223551, NC00220208, NC00219317 and NC00229831. Intake NC00229831 resulted in immediate jeopardy. 21 of 85 allegations resulted in deficiency.	F 000		

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

Electronically Signed | 05/22/2025

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F 000	Continued From page 1 Immediate Jeopardy was identified at: CFR 483.25 at tage F689 at a scope and severity of (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/19/25 and was removed on 05/01/25. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		5/6/25

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F 550	Continued From page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, and family member and staff interviews, the facility failed to ensure a dependent resident (Resident #158) had a functioning call light to call staff for assistance with care. Resident #158 told her family member it made her feel "helpless" not being able to call for assistance. A reasonable person would expect to have their call light function so they could call staff for assistance with care when needed. This deficient practice affected 1 of 3 residents reviewed for dignity and respect (Resident #158). The findings included: Resident #158 was admitted to the facility on 09/11/23. Review of Resident #158's annual Minimum Data Set (MDS) assessment dated 01/25/25 revealed she was severely cognitively impaired but could	F 550	F550 Corrective Action for resident found to have been affected. • Resident #158 call light was immediately placed and checked for functioning by licensed nursing staff on 12/28/24 when occurrence was reported. Corrective Action for any other resident having the potential to be affected. • On 12/28/24 the weekend supervisor and maintenance director completed 100% audit of all residents call lights. No other residents were affected, and no additional concerns noted with call lights. • On 5/5/25 the Social Worker interviewed residents with BIMs (Brief Interview Mental Status) 10 and over regarding customer service/care needs and treatment with dignity and any	

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F 550	Continued From page 3 make her needs known. Resident #158 required substantial/maximal assistance to dependence for all activities of daily living (ADL) care except eating in which she required setup. Resident #158 was incontinent of bowel and bladder and required staff assistance with toileting hygiene. Review of Resident #158's care plan dated 01/25/25 revealed a focus area for Resident # 158 requiring assistance for ADL care related to limited mobility. The goal was for the resident's ADL care needs to be anticipated and met throughout the next review period. The interventions included in part: - Provide resident with assistance for eating, dressing, toileting, transfers, bathing, oral hygiene, personal hygiene, and bed mobility as needed. Review of a grievance form completed on 12/28/24 by the former Administrator revealed a family member had filed a grievance regarding Resident #158's call light issue. The grievance was assigned to the Administrator, and a meeting was held with the family member of Resident #158, the former Administrator, the Regional Director of Operations and the Regional Director of Clinical Services. According to the grievance a self-imposed plan of correction was initiated and 100% audit of all call lights was done to ensure proper working call lights for all residents, timeline of care was completed for Resident #158 to ensure there were no issues with care and all staff received training on call light protocols and audits were completed to ensure working call lights throughout the facility for all residents. Written notification was provided to the family member of Resident #158 and a one-to-one discussion was provided with the family member	F 550	concerns related to call lights. On 5/5/25 the Social Worker completed Psychosocial INPOC for residents with BIMS of 9 and under to assess needs being met. No concerns noted. Measures will be put in place to ensure that the deficient practice will not recur. • On 12/28/24 the weekend supervisor initiated in-service education to all staff regarding ensuring call lights are within reach of resident and properly functioning to maintain resident dignity. Education to staff to continue with new hires, agency staff and prior to receiving assignment. This education will be ongoing. How facility plans to monitor its performance to ensure that compliance maintained. • The Director of Nursing or Assistant Director of Nursing will audit 5 residents, 5 days a week for 4 weeks. Then 3 residents 5 days a week for 4 weeks to ensure functioning call lights and ability to communicate needs to staff. Audits to be conducted on all shifts. Results of this monitoring will be brought before the Quality Assurance and Performance Improvement Committee Quarterly. DOC-5/6/25	

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F 550	Continued From page 4	F 550		

and staff.

An interview on 04/08/25 at 10:21 AM with the former Administrator revealed she recalled Resident #158's call light being tampered with by using a temperature probe and unplugging the call light so the resident could not call staff for assistance. The former Administrator stated it had happened, but they were unable to determine when it had happened or who had done it.

A telephone interview on 04/07/25 at 2:42 PM with the family member revealed she had visited Resident #158 on 12/28/24 and when she arrived at the facility the resident's call light was not working. The family member stated she looked at the call light on the wall and it was unplugged and a temperature probe had been placed in the plug to prevent the call light from alarming. The family member reported the incident to the former Administrator who completed a grievance. The family member stated Resident #158 told her it made the resident feel "helpless" not being able to call for assistance with care when her call light was not working. The family member further stated the call light had been working on 12/27/25 when she had visited the resident during the day.

An interview on 04/08/25 at 2:23 PM with Nurse Aide (NA) #3 who was assigned to care for Resident #158 during the 7:00 AM to 3:00 PM shift on 12/28/24 stated she noticed the call light was not plugged in when she was making rounds around 10:00 AM on the resident. NA #3 stated she thought maintenance had put something in the plug because they were working on the call light so she gave Resident #158 the call light from the empty bed next to her bed after she tested it and it worked. She further stated it wasn't until

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F 550	Continued From page 5	F 550		

later that day when the family member visited the resident that the family member told her Resident #158's call light was not working because someone had tampered with the call light. NA #3 further indicated she had no idea how long the call light had not been working when she found it that morning on 12/28/24. According to NA #3 Resident #158 was able to use her call light to call for assistance when she needed care.

An interview on 04/09/25 at 11:18 AM with NA #5 revealed she recalled taking care of Resident #158. She stated the resident was very pleasant and she was able to use her call light to alert staff of her care needs. NA #5 stated at times Resident #158 rang her call light even when she didn't need assistance or care.

An interview on 04/10/25 at 4:15 PM with Unit Manager #1 revealed she recalled Resident #158 and stated she was familiar with the issue with her call light being tampered with and not working. Unit Manager #1 stated Resident #158 was able to use her call light to alert staff when she needed care. She further stated they were never able to determine who tampered with Resident #158's call light.

A telephone interview was attempted multiple times with the nurse assigned to care for Resident #158 on the 7:00 AM to 3:00 PM shift on 12/28/24 without success.

An interview on 04/10/25 at 5:07 PM with the Director of Nursing and Administrator revealed it was their expectation that all residents had functioning call lights to allow them to call staff for assistance with care.

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F 554	Continued From page 6	F 554		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to stop a resident who had been assessed and determined clinically unsafe to self-medicate from self-medicating medications for 1 of 1 resident reviewed for self-administration of medication (Resident # 99). The findings included: Resident #99 was admitted to the facility on 01/14/25 with diagnoses including chronic obstructive pulmonary disease (COPD) and acute respiratory failure with hypoxia. Review of the self-administration of medication assessment dated 01/14/25 revealed Resident #99 had been assessed by the interdisciplinary team and determined he was clinically unsafe to self-medicate. The physician's order dated 01/14/25 revealed Resident #99 had an order to inhale 2 puffs of Budesonide-Formoterol (Symbicort) inhalation aerosol 80-4.5 micrograms (mcg) per actuation two times daily for shortness of breath. There was no order for the albuterol. Further review of Resident #99's physician orders since his admission on 01/14/25 revealed no medications were ordered to be left in his room for him to	F 554	F 554 Resident Self-Administration 1. On 4/15/25 Unit Manager completed self administration assessment on Resident # 99, the resident was unable to self administer medications appropriately. Unit manager removed the medications from resident # 99's room on 4/7/25 when medications were identified. On 4/7/25 the provider was made aware by Director of Nursing of resident # 99's utilization of medications at bedside, with no new orders. 2. Director of Nursing, Assistant Director of Nursing and Unit Managers completed self administration assessments on all residents, no residents identified as being able to self-administer on 4/15/25. Audit of all resident rooms identified as unable to self-administer completed on 4/15/25 by DON, ADON, UMs for presence of medications at bedside. Additional findings noted, all medications removed and stored on med cart 3. Education was provided for all staff by the Staff Development Coordinator on 4/15/25 regarding observing for medications in resident rooms, the	5/6/25

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F 554	Continued From page 7 self-medicate. Review of Resident #99's admission Minimum Data Set (MDS) assessment dated 01/17/25 revealed Resident #99 was coded with intact cognition and adequate vision. During the initial encounter with Resident #99 on 04/07/25 at 12:53 PM, the Surveyor asked Resident #99 if he kept any medication in his room. Resident #99 showed the Surveyor an opened Symbicort inhaler and an opened albuterol inhaler in the drawer of his bedside table. The manufacturer's expiration dates and opening dates for both inhalers were invisible during the observation. Resident #99 stated a few nursing staff were aware of his Symbicort and let him keep it in his room. However, he could not recall the names of these staff. On the other hand, none of the staff knew that he had an albuterol inhaler in his room. He explained he had breathing problems at times and needed to keep an albuterol inhaler with him in case he needed it as a rescue inhaler. He added he had used the inhalers a few times since admission. On 04/07/25 at 2:35 PM, a joint observation was conducted with Nurse Aide #2 (NA), Nurse #2, and Unit Manager #2 (UM). Resident #99 showed nursing staff the inhalers stored in the drawer of his bedside table. When the Surveyor asked Resident #99 in front of the nursing staff if he had ever used any of the 2 inhalers while in the facility, he confirmed he had used both inhalers but could not recall the exact dates. During an interview conducted on 04/07/25 at 2:38 PM, NA #2 stated she had provided care for Resident #99 but did not notice he had	F 554	process assessing for appropriateness of self-administration and obtaining orders as appropriate. 4. The Director of Nursing or designee will review 10 residents for completion of Medication Self-Administration Assessments and presence of medications at bedside a week for 4 weeks, then 5 residents a week for 4 week. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 5/06/25	

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F 554	Continued From page 8	F 554		

medications in his room. Otherwise, she would report the incident to the nurse.

An interview was conducted with Nurse #2 on 04/07/25 at 2:41 PM. She stated she was not aware of the 2 inhalers in Resident #99's room. Resident #99 was not allowed to keep medications in his room unless he was assessed as being able to self-medicate. Nurse #2 added Resident #99 had a physician's order to receive Symbicort inhaler but not the albuterol inhaler.

During an interview conducted on 04/07/25 at 2:48 PM, UM #2 stated the medications were most likely brought in by Resident #99's family. The Symbicort inhaler should be stored in the medication cart and albuterol should be returned to Resident #99's family unless he was assessed as being able to self-medicate and had a physician's order to self-medicate both inhalers.

An interview was conducted with the Director of Nursing (DON) on 04/08/25 at 2:55 PM. She explained the facility would not search for any resident's drawer without reasons and that was why nursing staff were not aware of the inhalers in the drawer of bedside table in Resident #99's room. She clarified that if the inhalers were visible to the nursing staff in Resident #99's room, she expected them to remove both inhalers as indicated.

On 04/10/25 at 5:29 PM, an interview was conducted with the Administrator. She expected residents who had been assessed by the interdisciplinary team and determined to be unsafe or clinically inappropriate to self-medicate to remain free of medications in their room.

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F 558	Continued From page 9	F 558		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §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. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure a call light was plugged in and in working order for 1 of 5 dependent residents who were reviewed for reasonable accommodation of needs (Resident #158). The findings included: Resident #158 was admitted to the facility on 09/11/23 with diagnoses which included diabetes mellitus type II, hypertension and dementia. The resident was discharged to the hospital on 02/01/25. Resident #158's quarterly MDS assessment dated 10/18/24 revealed she was severely cognitively impaired but was sometimes able to make her needs known. The assessment indicated Resident #158 required minimal to maximal assistance with activities of daily living and was always incontinent of bowel and bladder. Resident #158's annual Minimum Data Set (MDS) assessment dated 01/25/25 revealed she was severely cognitively impaired but was sometimes able to make her needs known. The assessment indicated Resident #158 required substantial to maximal assistance with activities	F 558	Past noncompliance: no plan of correction required.	

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F 558	Continued From page 10	F 558		

of daily living and was always incontinent of bowel and bladder.

Review of a grievance form completed on 12/28/24 by the former Administrator revealed a family member had filed a grievance regarding Resident #158's call light issue. The grievance was assigned to the Administrator and a meeting was held with the family member of Resident #158, the former Administrator, the Regional Director of Operations and the Regional Director of Clinical Services. According to the grievance a self-imposed plan of correction was initiated and 100% audit of all call lights was done to ensure proper working call lights for all residents, timeline of care was completed for Resident #158 to ensure there were no issues with care and all staff received training on call light protocols and audits were completed to ensure working call lights throughout the facility for all residents. Written notification was provided to the family member of Resident #158 and a one-to-one discussion was provided with the family member and staff.

A telephone interview on 04/07/25 at 2:42 PM with the family member revealed she had visited Resident #158 on 12/28/24 and when she arrived at the facility the resident's call light was not working. The family member stated she looked at the call light on the wall and it was unplugged and a temperature probe cover had been placed in the plug to prevent the call light from alarming. The family member reported the incident to the former Administrator who completed a grievance. The family member stated Resident #158 told her it made the resident feel "helpless" not being able to call for assistance with care when her call light was not working. The family member further

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stated the call light had been working on 12/27/25 when she had visited the resident during the day.

A telephone interview on 04/08/25 at 10:21 AM with the former Administrator revealed she recalled Resident #158's call light being tampered with by using a temperature probe cover and unplugging the call light so the resident was not able to call staff for assistance. She stated the resident could call staff for assistance by using her call light but on 12/28/24 it had been tampered with and was not working. The former Administrator further stated they were not able to determine who had tampered with the call light but said once they found out they had fixed the call light so that it worked for the resident.

An interview on 04/08/25 at 2:23 PM with Nurse Aide (NA) #3 who was assigned to care for Resident #158 during the 7:00 AM to 3:00 PM shift on 12/28/24 stated she noticed the call light was not plugged in when she was making rounds around 10:00 AM on the resident. NA #3 stated she thought maintenance had put something in the plug because they were working on the call light so she gave Resident #158 the call light from the empty bed next to her bed after she tested it and confirmed it worked. She further stated it wasn't until later that day when the family member visited the resident that the family member told her Resident #158's call light was not working because someone had tampered with the call light. NA #3 further indicated she had no idea how long the call light had not been working when she found it that morning on 12/28/24. According to NA #3 Resident #158 was able to use her call light to call for assistance when she needed care.

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An interview on 04/09/25 at 11:18 AM with NA #5 revealed she recalled taking care of Resident #158. She stated the resident was very pleasant and she was able to use her call light to alert staff of her care needs. NA #5 stated at times Resident #158 rang her call light even when she didn't need assistance or care.

An interview on 04/10/25 at 4:15 PM with Unit Manager #1 revealed she recalled Resident #158 and stated she was familiar with the issue with her call light being tampered with and not working. Unit Manager #1 stated Resident #158 was able to use her call light to alert staff when she needed care. She further stated they were never able to determine who tampered with Resident #158's call light.

A telephone interview was attempted multiple times with the nurse assigned to care for Resident #158 on the 7:00 AM to 3:00 PM shift on 12/28/24 without success.

An interview on 04/10/25 at 5:07 PM with the Director of Nursing and Administrator revealed it was their expectation that all residents had functioning call lights to allow them to call staff for assistance with care. The Administrator stated that there had been no further issues with resident call lights and that audits continued and no issues were found with call lights being tampered with or not functioning properly. She stated the call light audits were reviewed at each Quality Assurance and Performance Improvement (QAPI) meeting.

The facility provided the following corrective action plan:

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Address how corrective actions will be accomplished for those residents who have been affected by the deficient practice:

On 12/28/24 facility identified concern regarding functioning call light not being available to one resident. The Director of Nursing (DON) and Social Worker (SW) immediately completed physical and psychosocial assessment on affected resident with no negative findings. Call light was immediately made functional.

How will the facility identify other residents having the potential to be affected by the same deficient practice:

On 12/28/24 the facility initiated an audit by the Assistant Director of Nursing (ADON), Unit Managers (UMs) and Nursing Assistants (NAs) of all residents call lights and areas equipped with call lights to ensure they were within reach and functioning appropriately. No additional issues with call lights were noted. No additional residents were affected.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:

On 12/28/24 the weekend supervisor initiated in-service education to all staff regarding ensuring call lights are within reach of resident and properly functioning. Education of staff to continue upon return to work. Education for newly hired staff will be provided by DON, ADON or Unit Manager upon hire, prior to receiving assignment.

How will the facility monitor its corrective actions to ensure that the deficient practice will not recur:

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F 558	Continued From page 14 The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers (Ums) and/or Caring Angel will audit five residents, five days a week times four weeks, then three residents five days a week times four weeks to ensure residents call lights are within reach and properly functioning. These audits will be conducted on all three shifts. Results of this monitoring will be brought before the Quality Assurance and Performance Improvement Committee quarterly with the QAPI committee responsible for ongoing compliance. Compliance Date: 12/29/24. The corrective action plan was validated on 04/10/25. During the onsite validation on 04/10/25, call lights were tested and were functioning properly. Observations of call lights ringing and lighting up outside residents doors were completed. Staff interviews with Nurse Aides (NAs), Caring Angels, Unit Managers, and the DON revealed staff had received education on checking call lights to ensure they were functioning and within reach of the residents. Interviews with residents throughout the survey revealed their call lights were functioning and they were able to call staff for care needs. Audits of call lights being monitored were reviewed without any issues. The Administrator was interviewed and stated the results of the call light audits were discussed in each QAPI meeting. The corrective action plan's completion date of 12/29/24 was validated.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		5/6/25

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§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide

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F 578	Continued From page 16 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have advance directives accurate throughout the medical record for 2 of 4 residents (Resident #68 and Resident #48) reviewed for advance directives. The findings included: 1.Resident #68 was admitted to the facility on 12/3/24. Resident #68's care plan initiated on 12/18/24 indicated Resident #68's health directive was a full code. Interventions included to intercede rapidly and begin immediate resuscitative efforts utilizing all life-sustaining measures available if the resident's heart stops beating, or the resident stops breathing. The quarterly Minimum Data Set assessment dated 3/15/25 indicated Resident #68 was severely cognitively impaired. A review of Resident #68's medical record indicated a physician's order dated 2/28/25 for Do Not Resuscitate (DNR). The advance directive binder at the nurses' station indicated a DNR form for Resident #68 which was signed by the Medical Director on 2/24/25. An interview with Nurse #1 on 4/8/25 at 10:34 AM revealed she just started taking care of Resident #68 after he was transferred from another hall today. Nurse #1 stated that she would check Resident #68's chart to find out if he was full code	F 578	FTAG- 578 Based on record review and staff interview, the facility failed to ensure advanced directives for 2 of 4 residents. (Resident # 48 and # 68) 1. Resident #48 and #68 care plans were updated to reflect accurate and current code status orders. 2. 100 % audit off all residents' care plans to ensure accurate code status with no additional discrepancies noted. 3. Education was completed 4/10/2025 by the Regional Director of Clinical Reimbursement to the Social Workers and MDS Nurse. Education included requirement to ensure care plans reflect accurate and current advance directive orders as well as responsibility to update timely with any changes 4. Social Worker or Designee will audit care plans for accuracy of code status10 per week to ensure documentation of current code status order for 8 weeks, 5 per week to ensure documentation of current code status order for 8 weeks . Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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or DNR by looking at the current code status order. After reviewing Resident #68's care plan during the interview, Nurse #1 stated that it could cause confusion because Resident #68's care plan indicated he was a full code while he had a DNR form dated 2/24/25 in the advance directive binder. She further stated that the supervisor and the Social Worker were both responsible for the advance directives.

An interview with Unit Manager #1 on 4/8/25 at 10:43 AM revealed Resident #68's care plan was supposed to have been updated, but she wasn't sure who should have done it.

An interview with Minimum Data Set (MDS) Coordinator #1 on 4/8/25 at 10:46 AM revealed the Social Worker was responsible for revising the care plans regarding the advance directives.

An interview with Social Services Director (SSD) on 4/8/25 at 10:49 AM revealed she was one of the Social Workers who worked at the facility. The SSD stated that she was not aware that Resident #68's code status had been changed from full code to DNR. The SSD stated that the reason for this was that she was out on leave in February 2025, and they had another different Social Worker at that time who had quit. The SSD further stated that the Social Workers usually discussed the advance directives with the residents and their representatives whenever they wanted to update their advance directive, and they would update the care plan as well.

An interview with the Administrator on 4/10/25 at 5:23 PM revealed both the Social Workers and the MDS Coordinator were responsible for updating the care plans to indicate a change in

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the advance directives.

2.Resident #48 was admitted to the facility on 8/15/22.

Resident #48's care plan last revised on 9/11/23 indicated Resident #48's health directive was a full code. Interventions included to intercede rapidly and begin immediate resuscitative efforts utilizing all life-sustaining measures available if the resident's heart stops beating, or the resident stops breathing.

The modification of quarterly Minimum Data Set assessment dated 2/8/25 indicated Resident #48 was moderately cognitively impaired.

A review of Resident #48's medical record indicated a physician's order dated 4/3/25 for Do Not Resuscitate (DNR). The advance directive binder at the nurses' station indicated a DNR form for Resident #48 which was signed by the Medical Director on 4/3/25.

An interview with the Social Services Director (SSD) on 4/8/25 at 11:17 AM revealed Resident #48's code status must have changed after he came back to the facility from the hospital, and they didn't catch that it had changed. The SSD stated she didn't attend Resident #48's most recent care plan meeting, and that the Social Services Assistant told her that she didn't know that she was supposed to update the care plans when there was a change in advanced directives.

An interview with Minimum Data Set (MDS) Coordinator #1 on 4/8/25 at 11:24 AM revealed Resident #48's code status changed when they discussed this with his responsible party during

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F 578	Continued From page 19 his care plan meeting on 4/3/25. MDS Coordinator #1 stated that the Social Services Assistant attended the care plan meeting. An interview with the Social Services Assistant on 4/9/25 at 2:18 PM revealed she remembered being in Resident #48's care plan meeting on 4/3/25, and discussing about his code status changing from full code to DNR. The Social Services Assistant stated that she had Resident #48's DNR form signed by the Medical Director, let the nurse on the hall know so she could update the order, and placed it in the advance directive book at the nurses' station. She further stated that she didn't update the care plan regarding the advance directive, and was not sure who was responsible for doing that. She also stated that she was still in training, and had not been doing the full scope of her job duties as a Social Worker. An interview with the Administrator on 4/10/25 at 5:23 PM revealed both the Social Workers and the MDS Coordinator were responsible for updating the care plans to indicate a change in the advance directives.	F 578		
F 602 SS=G	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced	F 602		5/6/25

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by:
Based on record review, resident, and staff interviews, the facility failed to protect the resident's (Resident #76) right to be free from misappropriation of property when Hospitality Aide #1 used Resident #76's debit card to withdraw cash from an Automatic Teller Machine (ATM) and purchase various items from several stores without Resident #76's permission or knowledge. Hospitality Aide #1 was alleged to have spent approximately $628.75 on November 29, 2024. Resident #76 stated "it made me real sad that she took advantage of me." He indicated he trusted Hospitality Aide #1 as she had been kind to him and was upset she stole his money. This deficient practice occurred for 1 of 3 residents (Resident #76) reviewed for abuse, neglect, and misappropriation of resident property.

The findings included:

Resident #76 was admitted to the facility on 2/8/24.

A review of the quarterly Minimum Data Set (MDS) dated 11/13/24 indicated Resident #76 was cognitively intact.

A review of the facility's reportable incidents revealed an initial allegation report dated 12/3/24 indicating the facility became aware on 12/3/24 that money from Resident #76's personal bank account was missing. The report revealed Resident #76 gave Hospitality Aide #1 permission to purchase cigarettes with his debit card, but did not authorize additional purchases. The report indicated there was reasonable suspicion of a crime, and the alleged misappropriation of

F602
Corrective Action for resident found to have been affected.
• Resident #76 in agreement with restitution plan related to misappropriation. On 3/19/25 the Administrator met with the resident and agreed upon reimbursement plan as follows: Resident will inform the Administrator when he requires replenishment of cigarettes. Resident will inform the Administrator when he needs personal hygiene items several months. Resident and Administrator to determine when restitution achieved. Resident informed the Administrator that he preferred this method of reimbursement over receiving actual cash on 3/19/25.
Corrective Action for any other resident having the potential to be affected.
• On 12/3/24 and on 5/6/25 the Social Worker interviewed all residents with a BIMs score of 10 or higher with no resident concerns related to misappropriation. The Administrator reviewed resident trust on 5/6/25 for each resident to ensure no suspicious activity no concerns noted.
Measures will be put in place to ensure that the deficient practice will not recur.

• On 12/4/24 The Administrator provided education to all staff regarding the facility policy on misappropriation and not accepting any money or debit cards from residents. Newly hired, newly contracted and/or absent staff educated prior to accepting assignment.

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F 602	Continued From page 21 resident property was reported to law enforcement on 12/3/24. Hospitality Aide #1' statement indicated she used Resident #76's debit card to purchase items for herself, as well as withdrew cash at the ATM. A review of Resident #76's bank account record dated 12/20/24 revealed there were various transactions at local businesses, an ATM cash withdrawal, and an out of network ATM fee. The unauthorized transactions totaled approximately $628.75 and posted to his bank account on 12/2/24. A review of the police department incident report indicated a report was filed on 12/3/24 at 11:42 AM concerning Resident #76 and stolen money from his bank account. An interview with Resident #76 was conducted on 4/10/25 at 3:13 PM. He stated, "it made me real sad that she took advantage of me." Resident #76 stated he gave Hospitality Aide #1 his debit card to purchase cigarettes but did not authorize any of the other charges made on 11/29/24. He indicated Hospitality Aide #1 purchased him cigarettes with his debit card many times before, probably once a week for many months. A second interview with Resident #76 on 4/10/25 at 3:51 PM revealed Hospitality Aide #1 returned his debit card and brought him cigarettes after purchasing them on 11/29/24. He indicated a police report was completed, and charges were filed. Resident #76 indicated he was sad about the incident and hoped it was not Hospitality Aide #1 who took his money as she had been very kind to him and took good care of him. Resident #76 stated the Administrator had recently been	F 602	• Education on the right to be free from misappropriation will be reviewed each month at resident council meeting, this will be ongoing. If a resident needs assistance with purchasing an item, the social worker will contact their RP (Responsible Party)/ family /friends or whoever the RP designates to coordinate the purchase. If the resident does not have available RP, family/friends the social worker will coordinate the purchase with the facility business office. How facility plans to monitor its performance to ensure that compliance maintained. • Administrator will interview 10 residents per week for 4 weeks, then 5 residents per week for 3 weeks to ensure they have not given money or debit cards to any staff member excluding the business office. Results of this monitoring will be brought before the Quality Assurance and Performance Improvement Committee Quarterly. DOC-5/6/25	

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purchasing cigarettes for him as Hospitality Aide #1 was no longer purchasing them for him.

A third interview with Resident #76 on 4/10/25 at 9:06 AM revealed he had not been reimbursed yet for the stolen money and did not understand why it was taking so long for the facility to pay him back.

Multiple attempts were made to contact Hospitality Aide #1 and were unsuccessful.

A phone interview with the Former Business Office Manager (BOM) conducted on 4/14/25 at 9:17 AM. She revealed she was the BOM at the facility until the middle of March 2025. She explained Resident #76 came to her office to make a payment on his account. The debit card declined when we ran it for the full amount. The former BOM stated she assisted Resident #76 with calling his bank to hear his account balance and found out the unauthorized charges to include an ATM withdraw. She asked Resident #76 if he gave his card to someone, and he stated he had given it to Hospitality Aide #1 to buy him cigarettes. The Former BOM stated Resident #76 did not give permission for other charges. She stated she spoke with the facility's corporate team when this happened as she felt the facility should write off the balance for Resident #76. She was not aware of any efforts to reimburse Resident #76 but indicated she brought up the topic in her corporate meetings often. The Former BOM stated she was not aware of any efforts to purchase him anything such as cigarettes to reimburse him for the money that was stolen. She stated the cigarettes that were purchased for him were paid for with Resident #76's money. The Former BOM

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indicated when she left her position in March 2025, Resident #76 had not been reimbursed with cash or cigarettes.

A phone interview was conducted with the Former Administrator on 4/10/25 at 10:30 AM revealed Resident #76 took his debit card to the former Business Office Manager (BOM) at the beginning of December to pay his patient monthly liability (PML). The full amount of his PML would not go through when the card was processed. The Former BOM called the bank with Resident #76 and found the card had been used many times at various stores and one cash withdrawal at an ATM. The Former Administrator stated that Hospitality Aide #1 was terminated, as she stated she used Resident #76's debit card on various purchases and an ATM withdrawal without his permission. She stated a police report was filed, and charges were filed. The Former Administrator was not aware of any efforts made to reimburse Resident #76. She was unaware if the facility started a reimbursement process after she left her position at the end of February 2025.

An interview with the Administrator on 4/10/25 at 5:11 PM revealed she was made aware of the incident with Resident #76's debit card when she came to the facility in March. She stated she understood the Former Administrator investigated the stolen money incident and reported the incident to the State Survey Agency. The Administrator stated she discussed with Resident #76 the idea of reimbursing him for the money owed to him with cigarettes purchased on the corporate credit card for seven or eight months or however long it took to make up the stolen money. The Administrator stated she spoke to Resident #76 about the reimbursement plan the

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F 602	Continued From page 24 week before last when he ran out of cigarettes. The facility presented a plan of correction that was not accepted by the State Survey Agency. The facility indicated they started reimbursing Resident #76 with cigarettes after the incident, starting on 12/9/24. The facility failed to provide a timeline of cigarettes purchased for Resident #76 after the purchase of cigarettes on 12/9/24. The next receipts for cigarettes and a toiletry item submitted to the State Survey Agency were dated 4/9/25. An interview with the Former BOM on 4/14/25 at 9:17 AM revealed there was no plan for reimbursing Resident #76 when she left the facility in the middle of March and his cigarettes were purchased with his money, not the facility's. An interview with the Former Administrator on 4/14/25 revealed Resident #76 always relied on the facility to buy cigarettes, but there was no plan in place to purchase cigarettes continuously for reimbursement or any other kind of cash reimbursement. She indicated the facility bought Resident #76 cigarettes one time after the incident because he didn't have any to smoke. The Former Administrator stated it was a singular purchase and was not part of any reimbursement plan.	F 602		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument.	F 636		5/6/25

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F 636	Continued From page 25	F 636		

A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i)

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F 636	Continued From page 26 through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAA) comprehensively to address the underlying causes and contributing factors of the triggered areas for 2 of 6 sampled residents reviewed for CAA (Residents #99 and Resident #508). The findings included: a. Resident #99 was admitted to the facility on 01/14/25 with diagnoses including heart failure, diabetes mellitus, and atrial fibrillation. The admission Minimum Data Set (MDS) assessment dated 01/17/25 coded Resident #99 with intact cognition. A review of Section V (care area assessment summary) of the admission MDS assessment dated 01/17/25 revealed 7 care areas were triggered for Resident #99. Other than the care area for nutritional status, the MDS Coordinator #2 did not provide any information for analysis of findings for 6 of the 7 triggered areas to describe the nature of Resident 99's problems, root causes, contributing factors, risk factors related to	F 636	F636 Comprehensive Assessments Corrective Action for resident found to have been affected. • Updated Care Area Assessment Summaries (CAAS) were completed by licensed nurse on 4/9/25 for Resident #99 functional ability, urinary incontinence, falls, nutritional dehydration, pressure ulcers. Updated Care Area Assessment Summaries (CAAS) were completed by licensed nurse on 4/9/25 for Resident #508 functional ability, cognitive loss, visual function, urinary incontinence, falls, dehydration, pressure ulcers, psychotropic drug use. Corrective Action for any other resident having the potential to be affected. • All residents have the potential to be affected by the deficient practice. All Minimum Data Sets (MDS) were audited by a licensed nurse to ensure the CAAS comprehensively address the underlying causes and contributing factors of the triggered areas for that resident. Any findings were corrected by 5/6/25.	

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F 636	Continued From page 27 the care area, and reasons to proceed with care planning for the following triggered care areas: 1. Communication 2. Functional abilities (self-care and mobility) 3. Urinary incontinence and indwelling catheter 4. Falls 5. Dehydration/Fluid maintenance 6. Pressure ulcer/injury b. Resident #508 was admitted to the facility on 01/21/25 with diagnoses including non-Alzheimer's dementia, anxiety disorder, and depression. The admission MDS assessment dated 01/24/25 coded Resident #508 with severely impaired cognition. A review of Section V (care area assessment summary) of the admission MDS assessment dated 01/24/25 revealed 9 care areas were triggered for Resident #508. Other than the care area for nutritional status, the MDS Coordinator #2 did not provide any information for analysis of findings for 8 of the 9 triggered areas to describe the nature of Resident 508's problems, root causes, contributing factors, risk factors related to the care area, and reasons to proceed with care planning for the following triggered care areas: 1. Cognitive loss/dementia 2. Visual function 3. Functional abilities (self-care and mobility) 4. Urinary incontinence and indwelling catheter 5. Falls 6. Dehydration/fluid maintenance 7. Pressure ulcer/injury 8. Psychotropic drug use	F 636	Measures will be put in place to ensure that the deficient practice will not recur. • All licensed nurses responsible for completing CAAS were educated by the Regional MDS Nurse on 4/10/25 that CAAS must comprehensively address underlying causes and contributing factors of a triggered area for each resident. Newly hired or agency staff will be trained prior to completing an MDS in the facility. How facility plans to monitor its performance to ensure that compliance maintained. • The Regional MDS Coordinator will review all the weekly submitted MDS batches that have comprehensive assessments comprehensively address the underlying causes and contributing factors of the triggered areas for that resident. This will be completed weekly for 8 weeks and data will be reviewed at the Quarterly Quality Assurance Meeting. DOC 5/6/25	

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F 636	Continued From page 28 During an interview conducted on 04/09/25 at 9:22 AM, MDS Coordinator #2 confirmed 6 of the 7 triggered care areas for Resident #99's admission MDS dated 01/17/25 and 8 of the 9 triggered care areas for Resident #508's admission MDS dated 01/24/25 were submitted without providing any information for analysis of findings in Section V. She stated she was responsible for both MDS and acknowledged that it was an error to submit them without completing analysis of findings comprehensively for any of the triggered areas. She could not explain how it happened and added she would correct the errors and resubmit both MDS as soon as possible. On 04/09/25 at 10:01 AM an interview was conducted with the Director of Nursing. She stated all the CAAs must be individualized and completed comprehensively. It was her expectation for the MDS Coordinators to complete the analysis of findings for all the triggered areas in Section V comprehensively before submission. An interview was conducted with the Administrator on 04/10/25 at 5:29 PM. She expected the MDS Coordinator to follow MDS guidelines and completed all the CAAs comprehensively before submission.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		5/6/25

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F 641	Continued From page 29	F 641		

by:
Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for respiratory care (Resident #91), antibiotic use (Resident #48), and PASRR (Resident #63) for 3 of 29 resident assessments reviewed.

Findings included:

1. Resident #91 was admitted to the facility on 05/22/24 with a diagnosis of sleep apnea.

A physician order dated 12/11/24 revealed Resident #91 wore a continuous positive airway pressure (CPAP). The order was for staff to apply nightly as tolerated and to remove the CPAP in the morning.

Review of Resident #91's quarterly MDS assessment dated 02/27/25 revealed the resident was coded as having no CPAP device.

Review of Resident #91's medication administration record (MAR) for February 2025 revealed an order which read, "CPAP remove every A.M. when resident wakes, every day and night shift." The order was initialed as completed by nursing staff during the lookback period.

On 04/09/25 at 11:08 AM an interview was conducted with Nurse Aide (NA) 5. During the interview she stated Resident #91 had a CPAP machine that was applied nightly.

On 04/10/25 at 10:11 AM an interview was conducted with Nurse #3. During the interview Nurse #3 stated Resident #91 had a CPAP that was applied nightly and removed in the morning.

F 641 Accuracy of Assessments
Corrective Action for resident found to have been affected.
• Resident #91, #48 and #63.
Assessments were corrected on 4/9/25 and resubmitted by the MDS Assessment Nurse.
Corrective Action for any other resident having the potential to be affected.
• All other residents have potential to be affected. The MDS Assessment Nurse completed 100% audit of last completed MDS with Antibiotic orders, all with CPAP orders, all with Schizoaffective diagnosis to ensure PASRR. Completed 4/9/25 and corrections made as needed.
Measures will be put in place to ensure that the deficient practice will not recur.
• The Regional MDS Coordinator educated the MDS Nurses on 4/10/25 about MDS coding accuracy regarding special treatments, procedures and programs with emphasis on non-invasive mechanical ventilator, Antibiotics, high risk medications and PASRR. The Regional MDS Coordinator will review the orders listing weekly to ensure ongoing compliance with accuracy related to orders and/or changes especially related not deficient practice. This monitoring will be ongoing.
How facility plans to monitor its performance to ensure that compliance maintained.
• The Regional MDS Coordinator will review the orders listing weekly for 8 weeks to ensure ongoing compliance with accuracy. This data will be reviewed

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F 641	Continued From page 30 The interview revealed the physician order was located on the MAR and nursing staff were to sign off if the CPAP was in place for Resident #91. On 04/09/25 at 10:27 AM an interview was conducted with MDS Nurse #1. She stated she had been responsible for MDS for over a year and a half. The interview revealed she collected her information from the MAR and Treatment Administration Record (TAR) to decide how to code residents for respiratory care. MDS Nurse #1 stated after review of Resident #91's MAR, the MDS had not been coded correctly. She stated, "it was just missed". On 04/10/25 at 5:26 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated she would like for the MDS staff to accurately code all residents for respiratory care. On 04/10/25 at 5:45 PM an interview was conducted with the Administrator. She stated she would expect Resident #91's MDS to be accurately coded. 2. Resident #48 was admitted to the facility on 8/15/22. The modification of quarterly Minimum Data Set (MDS) assessment dated 2/8/25 revealed Resident #48 was taking antibiotics with indication noted. A review of the Medication Administration Record for Resident #48 for February 2025 indicated he did not receive antibiotics from 2/1/25 to 2/8/25.	F 641	during the Quarterly Quality Assurance meeting. DOC-5/6/25	

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F 641	Continued From page 31	F 641		

An interview with MDS Coordinator #2 on 4/9/25 at 3:15 PM revealed Resident #48 was on antibiotics right before he went to the hospital on 1/30/25, but after he came back to the facility on 2/3/25, he didn't receive any antibiotics. MDS Coordinator #2 stated that when she reviewed Resident #48's Medication Administration Record from the hospital, she noted that Resident #48 did not receive any antibiotics during the 7-day assessment period. MDS Coordinator #2 further stated that the MDS was marked in error.

An interview with the Administrator on 4/10/25 at 5:23 PM revealed the MDS should be coded correctly.

3. Resident #63 was admitted to the facility 2/21/25 with diagnoses that included schizoaffective disorder.

Resident #63's Preadmission Screening and Resident Review (PASRR) level II determination letter dated 2/20/25 revealed nursing facility placement was appropriate for 30 days and the PASRR level II expired on 3/22/25.

The admission Minimum Data Set (MDS) assessment dated 2/26/25 revealed Resident #63 had a diagnosis of schizoaffective disorder but was not coded for a PASRR level II.

An interview with MDS Nurse #2 on 04/09/25 at 2:27 PM revealed she was responsible for completing the PASRR level II section of the MDS. MDS Nurse #2 revealed she reviewed Resident #63's PASRR determination letter but was not familiar with a PASRR level II that expired after 30 days and thought it was a PASRR level I. MDS Nurse #2 stated the

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F 641	Continued From page 32 admission MDS was not coded accurately because she was unaware Resident #63 had a PASRR level II. During an interview with the Administrator on 4/10/25 at 5:27 PM she indicated a PASRR level II determination should be coded accurately on the resident's MDS assessment.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level II was obtained for a resident with an expired PASRR level II. This deficient practice occurred for 1 of 4 residents reviewed for PASRR (Resident #63).	F 644	FTAG- 644 Based on record review and staff interview, facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level 2. For 1 of 4 residents	5/6/25

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F 644	Continued From page 33 The findings included: Resident #63 was admitted to the facility on 2/21/25 with diagnoses that included schizoaffective disorder. Review of the Preadmission Screening and Resident Review (PASRR) level II dated 2/20/25 revealed it expired on 3/22/25. Resident #63 remained in the facility after 3/22/25 and a level II PASRR had not been completed since admission. An interview with the Social Services Director on 4/09/25 at 9:58 AM revealed she was responsible for monitoring and ensuring all level II PASRRs were obtained. She stated Resident #63 was admitted to the facility with a 30-day level II PASRR that expired on 3/22/25. She indicated Resident #63 remained in the facility after 3/22/25 and a new level II PASRR should have been requested but was overlooked. During an interview with the Administrator on 4/09/25 02:27 PM she revealed the Social Services Director was responsible for monitoring and ensuring all level II PASRRs were obtained. She stated if a resident was admitted with a PASRR level II that expired after 30 days, and they remained in the facility, a new level II PASRR should be obtained.	F 644	1. on 4/7/2025 Resident # 63 PASRR was updated by Social Worker, 2. On 4/7/25 the Social Worker and MDS Nurse Completed a 100 % audit off all residents with PASARR level 2 to ensure they have not expired with no other concerns noted. 3. Education was completed 4/8/2025 by the Administrator to the Social Workers. This education included looking at mental health diagnosis, new admission, and requirement to ensure facility maintains an unexpired PASRR on each Resident also to see if they are or need to be screened for level 2 PASRR. 4. Social Worker or Designee will audit all new admission and current residents weekly for 6 weeks for PASARR expiration. Social Worker, or Designee will audit Monthly residents 3 for Months for PASARR expiration. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. Mock Code Drills will be conducted by the Administrator and Director of Nursing monthly to ensure compliance with response time and location of crash carts. The Crash Carts will be audited by the Assistant Director of Nursing or designee 5 X week for 8 weeks and then 1 time weekly X 8 weeks to ensure appropriately stocked. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee	

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F 644	Continued From page 34	F 644	responsible for ongoing compliance. 5. Date of Compliance 5/6/25	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to administer medications as ordered by the physician for 1 of 5 (Resident #2) residents reviewed for medications. Findings included: a. Resident #2 was initially admitted to the facility on 2/10/2024 and readmitted from the hospital on 1/13/2025. Resident #2 had diagnoses including chronic diastolic congestive heart failure, Type 2 diabetes Mellitus with diabetic polyneuropathy (a condition where nerve damage occurs due to persistently high blood sugar levels), intervertebral disc degeneration lumbar region without mention of lumbar back pain or lower extremity pain. Review of quarterly Minimum Data Set (MDS) assessment dated 3/31/2025 revealed Resident #2 was cognitively intact. Resident #2's Physician's order dated 7/24/2024 read Pregabalin Oral Capsule 200mg (narcotic controlled substance) Give one capsule by mouth two times a day for Neuropathy (weakness,	F 658	F 658 Professional Standards 1. Resident # 2 is currently receiving all medications as ordered. A pain assessment was completed on 4/15/25 for Resident #2 with no pain noted. Provider made aware on 4/15/25 of any missed doses of medication, no new orders noted. 2. A) Director of Nursing and Nursing managers completed 100% audit on 4/15/25 of all declining count sheets to ensure accurate documentation on the Medication Administration Record (MAR). Provider was notified of any negative findings on 4/15/25 by Director of Nursing with no new orders. 3. Education was provided on 4/15/25 to Licensed Nurses and Medication Aides by the Staff Development Coordinator on ensuring accurate documentation upon administration of controlled medications on declining count sheet as well as MAR.	5/6/25

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F 658	Continued From page 35 numbness and pain from nerve damage) Resident #2's controlled medication declining sheets from October 2024 to April 2025 were reviewed and indicated Resident #2 had not received her scheduled doses of pregabalin 200mg on: 10/20/2025 at 4:00pm 2/27/2025 at 9:00am 3/6/2025 at 9:00am 3/18/2025 at 9:00pm 3/27/2025 at 9:00am Review of Resident #2's October 2024 Medication Administration Record (MAR) indicated: Nurse #10 documented on 10/20/2024 at 4:00pm pregabalin 200mg was administered. Review of Resident #2's February 2025 MAR indicated: Nurse #14 documented on 2/27/2025 at 9:00am pregabalin 200mg was administered. Review of Resident #2's March MAR indicated: Nurse #19 documented on 3/6/2024 at 9:00am pregabalin 200mg administered. Nurse # 1 documented on 3/18/2024 at 9:00pm pregabalin 200mg was administered. Medication Aide (MA) #2 documented on 3/27/2024 at 9:00am pregabalin 200mg was administered. During an interview on 4/10/2025 at 3:10pm MA #2 verified that she worked on 3/27/2025 and did not administer pregabalin 200mg to Resident #2 at 9:00am even though it was signed on the MAR. MA #2 stated she normally worked on	F 658	4. Director of Nursing anxd/or Assistant Director of Nursing to audit 5 declining count sheets 5 days a week X 4 weeks then 10 declining count sheets weekly X 4 weeks to ensure declining count sheet reflects MAR documentation. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 5/6/25	

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second shift but came in early to help that day and must have just missed it by accident.

During a telephone interview on 4/11/2025 at 10:11am Nurse #1 stated she had been at the facility as an agency nurse for a year but just signed on as a fulltime staff at the facility. Nurse #1 stated she would agree that she had not administered pregabalin if the narcotic count was correct and she had not signed it out on the narcotic declining inventory sheet.

During a telephone interview on 4/11/2025 at 5:18pm Nurse #10 stated if she had signed a med was administered on the MAR, but not on the controlled medication declining count sheets, and the count was correct, then she probably did not administer the medication.

Attempted to interview Nurse #19, but phone calls were not returned.

During an interview on 4/10/2025 at 11:57am the Director of Nursing (DON) stated if a resident had a medication signed out on the Medication Administration record but not on the controlled medication declining sheets, and the count was correct, then the medication had probably not been administered.

The Medical Director (MD) was interviewed on 4/10/2025 at 12:37pm and stated missing doses of pregabalin could cause increased pain or discomfort. The MD expected staff to document accurately and honestly on the MAR and narcotic record and for residents to receive their medications as ordered.

During an interview on 4/10/2025 at 5:30pm the

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Administrator stated she would expect a resident to receive medication as ordered. The Administrator stated she would expect staff to document accurately and honestly on the MAR.

b. Resident #2's Physician order dated 1/13/2025 read Tramadol HCL Oral tablet 50 milligram(mg) (narcotic controlled substance) Give one tablet by mouth every six hours as needed for pain.

Review of Resident #2's controlled medication declining sheets for March-April 2025 revealed Resident #2 had received tramadol HCL 75mg on 3/6/2025, 3/8/2025, 3/11/2025, 3/12/2025, 3/16/2025, 3/17/2025, 3/19/2025, 4/5/2025 and 4/6/2025.

During an interview on 4/10/2025 at 11:50am Unit Manager #2 verified Resident #2's controlled medication declining sheets indicated 75mg of tramadol HCL had been administered on 3/6/2025, 3/8/2025, 3/11/2025, 3/12/2025, 3/16/2025, 3/17/2025, 3/19/2025, 4/5/2025 and 4/6/2025.

During an interview on 4/10/2025 at 11:21am Nurse #6 verified Resident #2 had an order for tramadol HCL 50mg by mouth every 6 hours as needed for pain, and that Nurse #6 administered tramadol HCL 75 mg to Resident #2 on 3/11/2025 and 3/19/2025.

During a telephone interview on 4/10/2025 at 2:58pm Nurse #11 stated that maybe she didn ' t read the label correctly. Nurse #11 stated if she documented she gave tramadol HCL, she probably gave the 75mg in the blister pack. Nurse #11 stated she thought the correct dose of medication would be in the narcotic drawer.

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F 658	Continued From page 38 During a telephone interview on 4/11/2025 at 11:48am Nurse #9 stated if she had signed she had administered tramadol HCL, she probably gave 75mg. During a telephone interview on 4/11/2025 at 12:02pm Nurse #8 stated she was an agency nurse and if tramadol HCL 75mg was in the blister pack, that was what she administered. During an interview on 4/10/2025 at 11:57am the Director of Nursing (DON) verified Resident #2 had an order for tramadol HCL 50mg one tab by mouth every 6 hours as needed dated 1/13/2025, and that Resident #2's medication blister packs of tramadol HCL contained 75mg in each blister pack. The Medical Director (MD) was interviewed on 4/10/2025 at 12:37pm and stated it was not good that Resident #2 had received the wrong dose of tramadol HCL multiple times. During an interview on 4/10/2025 the Administrator stated she would expect a resident to receive medication as ordered. The Administrator stated she would expect staff to document accurately and honestly on the MAR.	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		5/6/25

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F 689	Continued From page 39 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and Nurse Practitioner, resident, and staff interviews, the facility failed to provide effective supervision for Resident #3 who had dementia with severe cognitive impairment, hemiparesis (mild or moderate weakness) of the dominant right side due to a stroke, and a history of smoking. A smoking assessent completed on 12/20/24 noted Resident #3 had limited range of motion and unclear speech response but was determined as having no issues with her ability to smoke safely and was determined to be safe to smoke unsupervised. On 3/19/25, Resident #3 was smoking unsupervised in the designated smoking area and caught her hair on fire. Resident #3 patted her hair with her right hand to put out the fire. Resident #3's hair was singed on her right side at least one inch starting from her hairline at her right ear through her hairline to the center part of her hair. Resident #3's right eye lid was blistered, and the palm of her right hand and behind her right ear also received mild burns and all were treated with a topical antibiotic cream. The smoking assessment completed 3/19/25 determined Resident #3 required staff supervision with smoking due to being unable to safely light smoking materials, hold smoking materials safely, and unable to call for emergency assistance. On Sunday 4/20/25 Resident #3 exited the front entrance of the building in her wheelchair and self- propelled herself 151 feet from the entrance of the facility through the parking lot to the parking lot entrance/exit area and was headed toward the main road without staff knowledge. The main road in front of the	F 689	F689 • Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance Facility failed to have effective systems in place to ensure all residents are being appropriately assessed for the correct level of supervision required for smoking to prevent accidents. Facility failed to have effective systems in place to ensure severely cognitively impaired residents are not leaving the building unsupervised to prevent accidents. • On 12/30/24 a smoking assessment was completed for resident by MDS. The smoking assessment found resident able to smoke unsupervised. Resident had been previously assessed as requiring supervision while smoking due to being unable to hold smoking materials safely or respond to fallen ashes quickly. On 3/19/25 Resident was assessed by licensed nurse with injuries noted to the right forehead, right ear, and right hand pursuant to a smoking incident. The provider was notified by the Director of Nursing with treatment orders obtained. The facility initiated a therapy referral for positioning while in wheelchair on 3/19/25. Therapy followed resident with plan of treatment. The responsible party was notified of incident, follow up treatment	

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F 689	Continued From page 40 facility and was four lanes with a speed limit of 35 miles per hour. A facility visitor who was leaving the parking lot telephoned the Weekend Nurse Supervisor around 7:00 PM and stated a resident was in her wheelchair outside at the parking lot entrance/exit and was wheeling herself towards the main road. The Weekend Nurse Supervisor notified Unit Manager #3 and they both responded to the parking lot where Resident #3 was found at the parking lot's entrance/exit area seated in her wheelchair facing the facility with her back towards the main road and self-propelling herself backwards up the exit incline towards the main road. Resident #3 did not have smoking material in her possession but told the staff she was in the parking lot because she wanted to smoke. This deficient practice had a high likelihood of causing serious harm or injury to Resident #3 and affected 1 of 3 residents reviewed for supervision to prevent accidents (Resident #3). Immediate jeopardy began on 3/19/25 when Resident #3 was smoking unsupervised and lit her hair on fire and again on 4/20/25 when Resident #3 exited the facility unsupervised and without staff knowledge. The immediate jeopardy was removed on 5/01/25 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. The findings included: Resident #3 was admitted to the facility on	F 689	plan and change in supervision with smoking with resident's consent. Resident's smoking assessment was re-evaluated by charge nurse on 3/19/25 and resident was notified that she was now a supervised smoker, resident verbalized understanding and in agreement. Despite some cognitive impairment she is oriented and conversant. Resident has expressive aphasia and able to communicate needs with some delayed verbalization. Staff notified of change in supervision with smoking and residents' apparatus by the Director of Nursing. Director of Nursing updated smoking binder that is in nurse's stations, front office and therapy department. • On 3/19/25 the facility ordered resident #3 a smoking adaptive apparatus to hold her cigarette. Being a supervised smoker, staff will light her cigarettes. Resident's care plan/ kardex updated to reflect that her hair is pulled back per resident acceptance. Smoking apron available per residents' acceptance. Resident has dementia and expressive aphasia and has ability to communicate needs and preferences, and facility will honor that per her rights while providing supervision to promote safety. • On 4/20/25 resident was witnessed by a family member in the parking lot approximately 20 feet from the road. The family stayed with the resident and notified the facility that resident was outside and safe as staff were not aware. The resident was witnessed less than 15	

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F 689	Continued From page 41 2/22/2010 with diagnoses that included stroke, expressive aphasia (partial loss of the ability to produce language), and hemiparesis (mild or moderate weakness) of the dominant right side, seizure disorder, and muscle weakness. Resident #3 was also diagnosed with dementia in 2015 and anxiety disorder, depression, and bipolar disease in 2018. Resident #3's quarterly smoking safety assessment completed by the previous Administrator dated 7/15/24 revealed Resident #3 was a smoker with a limited range of motion, weak grasps, diminished reflex response, and unclear speech response. Under the direct smoking observation section, Resident #3 was assessed as being unable to hold smoking materials safely and respond quickly to fallen ashes. Therefore, the smoking requirement for Resident #3's safety was for her to be a supervised smoker, wear a smoking apron, and smoking materials to be stored by the facility. The revised care plan dated 7/15/24 revealed Resident #3 was a smoker with a goal that she would not suffer any injuries from unsafe smoking practices through next review date. Interventions included Resident #3 could utilize cigarettes and smoke supervised, wear a smoking apron to protect her clothing, and had been instructed on smoking risks and hazards. Resident #3's quarterly Minimum Data Set (MDS) assessment dated 8/21/24 revealed she was severely cognitively impaired. Resident #3 was also assessed for use of tobacco, being ambulatory with assistance of a wheelchair, required substantial assistance for transfers, functional limitation of range of motion with	F 689	minutes prior to at the nurse's station. On 4/20/25 the Unit Manager assessed resident and there was no physical injuries and resident was not in any mental distress. Resident expressed she was not leaving and only wanted a cigarette. The Unit Manager assessed resident for wandering tendencies and resident did not present as a risk as she wanted to go outside and have a cigarette. Resident was provided with a cigarette in designated smoking area. Residents' preference for smoking times to be honored per request with staff supervision. On 4/29/25 facility made aware that resident did not prefer the smoking apparatus and discontinued the apparatus on 4/30/25. Resident can safely hold a cigarette with supervision. • Residents that smoke may have potential of being affected by deficient practice, therefore skin assessments were completed on all residents who smoke to ensure no burns identified from smoking. Assessments were completed by licensed nurses on 3/19/25. No areas of burns were identified. • The Director of Nursing and licensed nurses re-assessed all residents who wish to smoke for need of supervision and/or adaptive equipment, no additional residents were noted. Assessments were completed on 3/19/25. • On 3/19/25 The Director of nursing and licensed nurses reviewed care plans and Kardex's for all supervised and unsupervised smokers to ensure up to	

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F 689	Continued From page 42 impairments to the upper and lower extremities on one side, and no change in behaviors were noted. Resident #3's quarterly smoking safety assessment completed by the MDS Coordinator #2 dated 12/30/24 revealed Resident #3 was a smoker with limited range of motion and unclear speech response. Under the direct smoking observation section, Resident #3 was assessed as having no issues with her ability to smoke safely. Therefore, the smoking requirement for Resident #3's safety was changed for her to become an unsupervised smoker, no smoking apron required, and smoking materials continued to be stored by the facility. Care Plan updated to show change in smoking status from supervised to unsupervised. An interview with the MDS Coordinator #2 on 4/29/25 at 2:06 PM revealed she was familiar with Resident #3 and had completed her smoking evaluation on 12/30/24. She stated she had completed Resident #3's to the best of her knowledge and understanding of the questions. During her observation of Resident #3 smoking she felt Resident #3 was able to light, smoke, and dispose of her cigarette properly, and that was why she made her an unsupervised smoker. She revealed she was aware of Resident #3 being cognitively impaired and of her limited range of motion but felt that she was able to handle and smoke a cigarette safely. When asked if there had been any improvements or changes with Resident #3's cognition, functional abilities, or diagnosis since her last smoking assessment on 7/15/24, the MDS Coordinator #2 stated no but that she believed that Resident #3 was able to hold a cigarette and smoke it safely.	F 689	date and accurate with no additional concerns noted. • On 4/20/25 the charge nurse completed a resident headcount to ensure that all residents were accounted for. There were no concerns with any other residents. On 4/21/25 Social Service completed an updated Brief Interview for Mental Status (BIMs) on all residents to ensure accurate cognitive status. On 4/21/25 the Regional Nurse completed wandering assessments on all residents. On 4/21/25 the Regional Nurse reviewed a Behavior Summary Report on the previous week with no exit seeking concerns identified. • Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete • On 3/19/25 in-service education was initiated by the staff development coordinator to all nursing staff (licensed nurses, nursing assistants, medication aides) including agency regarding the facility's smoking policy (related to supervision and assistance). Beginning on 3/19/25 any absent staff, contracted, or newly hired staff will be educated prior to accepting assignments. The education is to be maintained by staff development coordinator. • A list of residents requiring adaptive	

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F 689	Continued From page 43 The revised care plan dated 12/30/24 revealed Resident #3 was a smoker with a goal that she would not suffer any injuries from unsafe smoking practices through next review date. Interventions included Resident #3 could utilize cigarettes and smoke unsupervised, observe clothing and skin for signs of cigarette burns, and had been instructed on smoking risks and hazards. Resident #3's annual MDS assessment dated 1/01/25 revealed she was severely cognitively impaired. Resident #3 was also assessed for use of tobacco, being ambulatory with assistance of a wheelchair, required partial assistance for transfers, functional limitation of range of motion with impairments to the upper and lower extremities on one side, and no change in behaviors were noted. Nursing progress note written by Nurse #3 dated 3/19/25 revealed Resident #3 was outside smoking when her hair caught fire. Hair to the right of her head was singed off. Ear and hand to right side noted red. Provider and Responsible Person was updated. The Medical Director responded with the following feedback: Continue to monitor any changes at this time. Resident #3's quarterly smoking assessment completed by Nurse #3 dated 3/19/25 revealed Resident #3 was a smoker with problematic short- and long-term memory, limited range of motion, and unclear speech. Under the direct smoking observations sections, Resident #3 was assessed as being unable to safely light smoking materials, hold smoking materials safely, and unable to call for emergency assistance. Therefore, the smoking requirement for Resident	F 689	equipment, and the equipment required is to be maintained at each nurse's station in the smoking binder for resident who smoke. Staff notified verbally to include staff who supervise smokers of updates to Kardex and smoking binder. Smoking binders located in nurse's stations, front office and therapy department and updated by the Director of Nursing as needed. • On 4/21/25 the Regional Director of Operations in serviced the Administrator regarding accurate BIMs assessment to ensure appropriate supervision as needed. On 4/21/25 the Regional Nurse initiated education to all staff regarding resident's preferences with smoking and appropriate supervision with residents wishing to go outside. Education of staff to continue upon return to work. Education for newly hired staff will be provided by the DON, ADON or Unit Manager upon hire and prior to receiving assignment. On 4/30/25 the Maintenance Director ensured front door keypad automatically locks at 5pm once the receptionist leaves. The 3-11 supervisor will ensure the front door is locked during evening rounds. Director of Nursing notified the 3-11 supervisor on 4/30/25. • On 4/29/25 the Director of Nursing, Assistant Director of Nursing and Nursing Managers reiterated education to all staff regarding residents smoking preferences and resident safety with supervision that wish to go outside. Newly hired staff, including agency nurses will receive in-service education prior to working their	

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F 689	Continued From page 44 #3's safety was for her to become a supervised smoker, wear a smoking apron, and smoking materials to be stored by the facility. A telephone interview with Nursing Assistant (NA) #7 on 4/29/25 at 3:11 PM revealed she was familiar with Resident #3. She stated on 3/19/25 she had gone into another resident's room to check on them and was looking out of their window to the smoking area and she observed Resident #3 outside at the smoking area patting on the side of her head. She revealed she left the other resident's room, went over to the door that leads out to the smoking area, and saw Resident #3 trying to open the door to come back inside the facility. NA #7 stated she opened the door for Resident #3 to come in and immediately noticed the smell of something burning and when she looked at Resident #3's hair she could tell it had been singed and the right side of her face at her hairline was red. She revealed she immediately assisted Resident #3 over to the nurse's desk and informed Nurse #3 what happened and then went to get the DON. She revealed Nurse #3, and the DON began treating Resident #3 and she went back to her residents. An interview with Nurse #3 on 4/29/25 at 12:34 PM revealed he was familiar with Resident #3. He stated he was standing at the nurse's desk on 3/19/25 when NA #7 brought Resident #3 over to him stating she believed Resident #3 had burned her hair while smoking. He revealed when he began to assess Resident #3, he observed that she had singed her hair starting from her hairline at her right ear up through the hairline at the center part of her hair. He stated he also observed that she had redness behind her right ear, on her face at her hairline, and to the palm of	F 689	initial shift. • Locking the door when unattended, updated wandering risk assessments and monitoring of residents with exit seeking behaviors will ensure cognitively impaired residents do not leave the facility unsupervised. IJ Removed 5/1/25 How facility plans to monitor its performance to ensure that compliance maintained. • The Director of Nursing and/or designee will monitor the alert listing report 5 days per week for 8 weeks for any wandering or unusual behaviors. The Director of Nursing and/or designee will monitor residents that smoke for appropriate supervision 7 days weekly for 8 weeks. The data will be reviewed during the Quarterly Quality Assurance meeting. DOC 5/6/25	

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her right hand. Nurse #3 revealed he asked Resident #3 what happened, and she stated she was smoking and her hair caught fire, and she put it out with her hand. He stated he notified the physician who told him to monitor, made a note for the NP to assess Resident #3 for burns, documented in the medical chart, and completed a new smoking assessment for Resident #3 to be a supervised smoker. He revealed after he finished assessing Resident #3, the Director of Nursing (DON) came and took Resident #3 back to her room.

Previous infection control nurse progress note dated 3/19/25 revealed the Nurse Practitioner (NP) notified of blistered area (second-degree burn) to right eyelid. New order to apply [a topical antibiotic cream used to treat and prevent infection of serious burns] to area twice a day and Tylenol 650 milligrams (MG) every 8 hours as needed for pain. Resident #3 to be evaluated by NP upon next round. Resident #3 was made aware.

NP order for Resident #3 dated 3/19/25 revealed Tylenol Oral Tablet 325 MG (Acetaminophen) give 2 tablets by mouth every 8 hours as needed for pain for 3 Days and apply [topical antibiotic cream] to right upper eyelid twice a day.

An NP progress note dated 3/20/25 revealed nursing staff reported Resident #3 was smoking outside and burned her right hand and behind her right ear. Resident #3 was a 72-year-old female seen per nursing request for burns to right hand and behind right ear due to smoking. Nursing staff requested a visit for initial evaluation and treatment of burns. The risk of complication was moderate. Burn of unspecified degree of right

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F 689	Continued From page 46	F 689		

hand, unspecified site, initial encounter: right hand burn was mild, only redness, no blistering, will start antibiotic cream to area twice a day. Burn of unspecified degree of head, face, and neck, unspecified site, initial encounter: Burn area behind left ear was mild, only redness noted, no blistering, will start antibiotic cream to area twice a day.

NP order for Resident #3 dated 3/20/25 revealed clean areas to right upper and lower eyelids, right ear, right face, right forehead and right hand with normal saline (NS) and apply [topical antibiotic cream] twice a day for burns.

Resident #3's March 2025 Medication Administration Record revealed she did not require the use of her as needed pain medication.

Resident #3 was observed on 4/29/25 at 10:30 AM outside smoking in the designated smoking area. The designated smoking area was a cemented area located inside the fenced courtyard, had a permanent shade to protect from the weather, tables, chairs, ash trays, and fire extinguisher available, and the area was accessible through a door in the dining room. Resident #3 was seated in her wheelchair wearing her smoking apron and using a smoking device to assist with smoking. The smoking device was an ash tray permanently mounted onto a flat wooden board, a long rubber tubing was attached to the ash tray by an adaptor on one end to hold the cigarette and allow ashes to fall into the ashtray safely, and a mouthpiece was attached at the other end of the tubing for Resident #3 to smoke safely. Hospitality Aide #1 was outside with Resident #3 supervising her while smoking. Resident #3 was observed to be

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able to smoke safely while using the device. When asked Resident #3 how she liked smoking with the device she kept frowning and shaking her head "No".

An interview and observation with Resident #3 on 4/29/25 at 11:30 AM revealed she was outside smoking unsupervised in the designated smoking area on 3/19/25 and her hair caught fire. She demonstrated she used the palm of her hand to pat out the fire. Observation of Resident #3's hair showed where at least 1 inch of the hair on the right side of head starting from the ear to the center part of head was singed off and was starting to grow back. Observations of Resident #3's palm of her right hand, behind her right ear, and top of her right eyelid revealed no signs of redness, mild burns, or scarring.

An interview with Hospitality Aide #1 on 4/29/25 at 10:40 AM revealed he was responsible for taking supervised smokers outside to smoke during their scheduled smoking times, apply their smoking aprons, provide them with their smoking materials from the locked box that was kept at the nurse's station. He stated there was a list of the supervised and unsupervised smokers kept at each nurse's desk, so he was aware of who smoked and if they were supervised or unsupervised. He revealed all smoking materials were kept inside the locked box located at the nurse's desk and residents who were unsupervised smokers would have to request their smoking materials prior to smoking and return their materials when they are finished. Hospitality Aide #1 stated supervised smokers were not allowed to have access to their smoking materials, staff provided them with their smoking materials, light their cigarettes for them, and then

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place their materials back into the locked box. He revealed supervised smokers have designated smoking times at 10:30 AM, 1:30 PM, and 6:30 PM.

An interview with the Nurse Practitioner (NP) on 4/29/25 at 11:00 AM revealed she was familiar with Resident #3. She stated she was notified by telephone on 3/19/25 of Resident #3's smoking incident where her hair caught fire causing some redness to the palm of her right hand and behind her right ear and a blister to her right eyelid. She revealed she ordered on 3/19/25 for a medicated cream to be applied to her right eyelid and an order for as needed pain medication. The NP stated she assessed Resident #3 in person on 3/20/25 and noted mild second-degree burns like a bad sunburn to the palm of her right hand and behind her left ear and continued the order for the medicated cream to the right eyelid to include the right hand and behind the right ear. She revealed she did not recall Resident #3 complaining of any pain from those areas, but she did have as needed pain medications ordered just in case. She stated she was not familiar with Resident #3's smoking abilities but would assume that based on her diagnosis and the fact that she does have some good and some bad days would most likely contribute to her inability to complete certain tasks such as smoking safely.

An interview with the Administrator and DON on 4/29/25 at 2:40 PM revealed they were familiar with Resident #3. The Administrator stated she was on leave when the smoking incident with Resident #3 occurred and was notified of the incident when she returned. The DON stated she was working at the facility on 3/19/25 when the smoking incident with Resident #3 occurred, she

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was notified by NA #7 that Resident #3 had caught her hair on fire while outside smoking. She revealed she went to the nurse station where Nurse #3 was assessing Resident #3 for injuries and observed the hair next to her hairline on the right side had been singed off and she did have some redness on her face, behind her ear, and to the palm of her right hand. The DON stated that after Nurse #3 completed his assessment, she assisted Resident #3 back to her room and asked her what happened, and Resident #3 stated that she was outside smoking, caught her hair on fire and put it out with her hand. She revealed Resident #3 did have right sided weakness with limited range of motion and because of that would sometimes lean more to her right side. The DON stated she had assumed that what caused the incident was Resident #3 had her hand that was holding her cigarette up and as she leaned, she caught her hair on fire. She revealed Resident #3 was an unsupervised smoker prior to the incident. The DON stated an updated smoking assessment was completed on 3/19/25 and Resident #3 was now a supervised smoker, wore a smoking apron, and used a smoking device.

Resident #3's wandering assessment dated 3/28/24 revealed no history of wandering or exit seeking behaviors and no interventions needed.

Resident #3's quarterly MDS assessment dated 4/10/25 revealed she was severely cognitively impaired. Resident #34 was also assessed as being ambulatory with assistance of a wheelchair, functional limitation of range of motion with impairments to the upper and lower extremities on one side, with no history of wandering or exit seeking behaviors.

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Nursing progress note written by Unit Manager #3 dated 4/20/25 revealed Resident #3 went outside into the front parking lot because "She wanted to go smoke", and believed if she went out of the front door staff would come quicker. Resident #3 stated she was not trying to leave the building.

A telephone interview with the Weekend Nurse Supervisor on 4/29/25 at 1:19 PM revealed she was familiar with Resident #3. She stated she was working on the evening of 4/20/25 and sometime between 7:00 PM and 7:15 PM she received a telephone call from a visitor who was leaving the facility parking lot (she could not recall the visitor's name) that a resident was out in the parking lot at the entrance/exit area and headed towards the road. She revealed she immediately went to get Unit Manager #3 and when they went outside to the parking lot, they found Resident #3 seated in her wheelchair at the entrance and exit area of the parking lot. Resident #3 was inside her wheelchair facing the facility with her back facing the road and was trying to wheel herself backwards up the entrance/exit incline towards the main road. The Weekend Nurse Supervisor stated she and Unit Manager #3 asked Resident #3 what she was doing out in the parking lot, and she stated she was going to smoke. She revealed she checked, and Resident #3 did not have any smoking materials on her and when asked if she was trying to leave the facility, Resident #3 kept saying she just wanted to go smoke. Weekend Nurse Supervisor stated Resident #3 was a supervised smoker and she had just taken her out to smoke in the designated smoking area for the last scheduled smoking time around 6:30 PM. She revealed after Resident #3 smoked her normal two cigarettes; she assisted Resident #3 back inside the facility which was probably around

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6:45 PM and she went back to the hall she was assigned, and Resident #3 was wheeling herself down the hall back towards her room. Weekend Nurse Supervisor stated she was not aware of Resident #3 asking any staff between the time she came back inside from smoking at 6:30 PM and the time she was found outside to go smoke. She stated Unit Manager #3 called the Administrator who advised to take Resident #3 back inside the facility, assess her for any injuries, and then take her to smoke. The Weekend Nurse Supervisor revealed Unit Manager #3 assessed Resident #3 with no injuries noted and then she took her out to smoke with no further issues. She stated to her knowledge Resident #3 had never displayed any wandering or exit-seeking behaviors and she felt this was an isolated incident where Resident #3 wanted to go back out to smoke and that was her way of getting staff's attention so they would take her to go smoke.

An interview with Unit Manager #3 on 4/29/25 at 11:42 AM revealed she was familiar with Resident #3. She stated she was working on the evening of 4/20/25 and sometime between 7:00 PM and 7:15 PM the Weekend Nurse Supervisor came to her stating Resident #3 was in the parking lot unattended. She revealed she and the Weekend Nurse Supervisor went outside to the parking lot and found Resident #3 in the parking lot at the bottom of the entrance and exit incline. Resident #3 was seated inside her wheelchair, the wheelchair was turned backwards with her back towards to road, and she was attempting to wheel herself up the incline towards the road. Unit Manager #3 stated she and the Weekend Nurse Supervisor asked Resident #3 why she was outside in the parking lot and where she was

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going and Resident #3 stated that she was going to smoke. She revealed Resident #3 continued to say that she was going to smoke and when asked if she was trying to leave the facility, Resident #3 shook her head "No" and said she was not leaving she just wanted to go smoke. The Unit Manager stated she called the Administrator and informed her of Resident #3 being out in the parking lot and the Administrator instructed her and the Weekend Nurse Supervisor to take Resident #3 back inside the facility, assess her for any injuries, and then take her out to smoke. Unit Manager #3 revealed she completed Resident #3's assessment with no injuries noted, the Weekend Nurse Supervisor took Resident #3 out to smoke, and there were no further issues the rest of the evening. She stated to her knowledge Resident #3 had never had any wandering behaviors before and she truly felt that she was just trying to get nursing staff's attention so they would take her out to smoke.

An interview with Resident #3 on 4/29/25 at 11:30 AM revealed on the evening of 4/20/25 she exited the facility to the parking lot and was heading towards the road to smoke when staff came and stopped her. She stated she did not have any smoking materials on her, she wanted to go smoke. When asked where she was going to get the smoking materials needed to smoke, Resident #3 stated she would get them at the road. When asked if she was trying to leave the facility, Resident #3 stated, "No" that she just wanted to go outside and smoke. When asked if she had gone outside to smoke during the last smoking time at 6:30 PM, Resident #3 stated "Yes" but she just wanted to go smoke. When asked if she had told staff she wanted to go back outside to smoke again, Resident #3 shook her

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head "No". When asked if she was aware of the concerns with her going outside in the parking lot towards the road in her wheelchair by herself, Resident #3 shook her head "No" and stated again that she was just trying to go smoke.

Attempted contact with NA #8 who was scheduled with Resident #3 on the evening of 4/20/25 was unsuccessful.

Attempted contact with NA #9 who was scheduled with Resident #3 on the evening of 4/20/25 was unsuccessful.

Observation of the facility and route taken by Resident #3 on 4/29/25 at 3:15 PM revealed the facility was a single-story building facing a main four lane road with a speed limit of 35 miles per hour, surrounded by multiple businesses, and within one mile of a hospital. The entrance to the facility was covered, open, with no sidewalks, and accessible from the front parking lot off from the main road. The route taken by Resident #3 as described by Unit Manager #3 and the Weekend Nurse Supervisor revealed Resident #3 was seated in her wheelchair and wheeled herself outside through the unlocked doors located at the front entrance of the facility, went into the front parking lot, took a right towards the parking lot entrance, and was found at the bottom of the incline at the parking lot entrance with her wheelchair turned backwards and wheeling herself towards the road. The estimated length from the front door entrance to the incline at the entrance parking lot was 151 feet, the incline at entrance of the parking lot was a slope of 10 inches, and starting from the bottom of the incline to the top of the incline located at the main road was 56 feet.

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Per weather.com the weather at the facility on 4/20/25 was sunny and clear, temperature was 78 degrees, and sunset was at 7:50 PM.

An interview was conducted with the NP on 4/29/25 at 11:00 AM revealed she was familiar with Resident #3. She stated she was not aware of the incident on 4/20/25 with Resident #3 leaving out of the facility and attempting to go towards the road. She revealed to her knowledge Resident #3 did not have a history of wandering but she still would have liked to have been informed of the incident so she could have assessed if this was an isolated incident related to wanting to go smoke, or a new behavior brought on by a change with her medical conditions. She stated Resident #3 does require a wheelchair for mobility, had right sided weakness with limited range of motion, and diagnosis of dementia, seizures, and expressive aphasia which could put her at risk of accidents in general. The NP revealed Resident #3, being out in the parking lot and attempting to ambulate herself towards the main road could certainly have put her at more of a risk of having a fall or being hit by a car.

An interview with the Administrator on 4/29/25 at 2:40 PM revealed she was familiar with Resident #3. The Administrator stated on the evening of 4/20/25 sometime after 7:00 PM she received a telephone call from Unit Manager #3 stating that Resident #3 was found outside the facility, on the sidewalk not far from the front porch. She stated Unit Manager #3 reported that when they found Resident #3 and asked her what she was doing outside that she told them that she was not trying to leave the facility, that she just wanted to go

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smoke. The Administrator revealed that she instructed Unit Manager #3 to take Resident #3 back inside and assess her for any injuries and then assist Resident #3 with going to smoke. She stated they did not implement any 15-minute checks just continued normal rounds because at that time they did not feel Resident #3 had tried to elope or that she was an elopement risk, she was just trying to get the staff's attention to go smoke. The Administrator revealed to her knowledge Resident #3 had never had any history with wandering or displayed any exit seeking behaviors and prior to this incident had gone out to the front porch to sit with no issues. She stated although she was never told Resident #3 was further out into the parking lot headed towards the road, she did not believe Resident #3 was ever trying to leave the facility, this was an isolated incident, and did not feel Resident #3 was ever an elopement risk. She revealed Resident #3 had been taken out to smoke during the designated smoking time at 6:30 PM, and she was not aware of her asking staff to go back outside again to smoke prior to exiting out of the front of the facility. The Administrator stated she was not aware of Resident #3 not liking the assigned smoking device and they would be reassessing Resident #3's smoking ability to see if there was another option for her to be able to smoke safely without using the smoking device.

The Administrator was notified of immediate jeopardy on 4/30/25 at 5:20 PM.

The facility provided the following plan for immediate jeopardy (IJ) removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as

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a result of the noncompliance

Facility failed to have effective systems in place to ensure all residents are being appropriately assessed for the correct level of supervision required for smoking to prevent accidents. Facility failed to have effective systems in place to ensure severely cognitively impaired residents are not leaving the building unsupervised to prevent accidents.

On 12/30/24 a smoking assessment was completed for resident by MDS. The smoking assessment found resident able to smoke unsupervised. Resident had been previously assessed as requiring supervision while smoking due to being unable to hold smoking materials safely or respond to fallen ashes quickly. On 3/19/25 Resident was assessed by licensed nurse with injuries noted to the right forehead, right ear, and right hand pursuant to a smoking incident. The Medical Director was notified by the Director of Nursing with treatment orders obtained. The facility initiated a therapy referral for positioning while in wheelchair on 3/19/25. Therapy followed resident with plan of treatment. The Responsible Person was notified of incident, follow up treatment plan and change in supervision with smoking with resident's consent. Resident's smoking assessment was re-evaluated by charge nurse on 3/19/25 and resident was notified that she was now a supervised smoker, resident verbalized understanding and in agreement. Despite some cognitive impairment she is oriented and conversant. Resident has expressive aphasia and able to communicate needs with some delayed verbalization. Staff notified of change in supervision with smoking and residents'

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apparatus by the Director of Nursing. Director of Nursing updated smoking binder that is in nurse's stations, front office and therapy department.

On 3/19/25 the facility ordered resident #3 a smoking adaptive apparatus to hold her cigarette. Being a supervised smoker, staff will light her cigarettes. Resident's care plan/ kardex updated to reflect that her hair is pulled back per resident acceptance. Smoking apron available per residents' acceptance. Resident has dementia and expressive aphasia and has ability to communicate needs and preferences, and facility will honor that per her rights while providing supervision to promote safety.

On 4/20/25 resident was witnessed by a family member in the parking lot approximately 20 feet from the road. The family stayed with the resident and notified the facility that resident was outside and safe as staff were not aware. The resident was witnessed less than 15 minutes prior to at the nurse's station. On 4/20/25 the Unit Manager assessed resident and there was no physical injuries and resident was not in any mental distress. Resident expressed she was not leaving and only wanted a cigarette. The Unit Manager assessed resident for wandering tendencies and resident did not present as a risk as she wanted to go outside and have a cigarette. Resident was provided with a cigarette in designated smoking area. Residents' preference for smoking times to be honored per request with staff supervision.

On 4/29/25 facility made aware that resident did not prefer the smoking apparatus and discontinued the apparatus on 4/30/25. Resident can safely hold a cigarette with supervision.

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Residents that smoke may have potential of being affected by deficient practice, therefore skin assessments were completed on all residents who smoke to ensure no burns identified from smoking. Assessments were completed by licensed nurses on 3/19/25. No areas of burns were identified.

The Director of Nursing and licensed nurses re-assessed all residents who wish to smoke for need of supervision and/or adaptive equipment, no additional residents were noted. Assessments were completed on 3/19/25.

On 3/19/25 The Director of nursing and licensed nurses reviewed care plans and Kardex's for all supervised and unsupervised smokers to ensure up to date and accurate with no additional concerns noted.

On 4/20/25 the charge nurse completed a resident headcount to ensure that all residents were accounted for. There were no concerns with any other residents. On 4/21/25 Social Service completed an updated Brief Interview for Mental Status (BIMs) on all residents to ensure accurate cognitive status. On 4/21/25 the Regional Nurse completed wandering assessments on all residents. On 4/21/25 the Regional Nurse reviewed a Behavior Summary Report on the previous week with no exit seeking concerns identified.

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

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F 689	Continued From page 59 On 3/19/25 in-service education was initiated by the staff development coordinator to all nursing staff (licensed nurses, nursing assistants, medication aides) including agency regarding the facility's smoking policy (related to supervision and assistance). Beginning on 3/19/25 any absent staff, contracted, or newly hired staff will be educated prior to accepting assignments. The education is to be maintained by staff development coordinator. A list of residents requiring adaptive equipment, and the equipment required is to be maintained at each nurse's station in the smoking binder for resident who smoke. Staff notified verbally to include staff who supervise smokers of updates to Kardex and smoking binder. Smoking binders located in nurse's stations, front office and therapy department and updated by the Director of Nursing as needed. On 4/21/25 the Regional Director of Operations in serviced the Administrator regarding accurate BIMs assessment to ensure appropriate supervision as needed. On 4/21/25 the Regional Nurse initiated education to all staff regarding resident's preferences with smoking and appropriate supervision with residents wishing to go outside. Education of staff to continue upon return to work. Education for newly hired staff will be provided by the DON, ADON or Unit Manager upon hire and prior to receiving assignment. On 4/30/25 the Maintenance Director ensured front door keypad automatically locks at 5pm once the receptionist leaves. The 3-11 supervisor will ensure the front door is locked during evening rounds. Director of Nursing notified the 3-11 supervisor on 4/30/25.	F 689		

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F 689	Continued From page 60 On 4/29/25 the Director of Nursing, Assistant Director of Nursing and Nursing Managers reiterated education to all staff regarding residents smoking preferences and resident safety with supervision that wish to go outside. Newly hired staff, including agency nurses will receive in-service education prior to working their initial shift. Locking the door when unattended, updated wandering risk assessments and monitoring of residents with exit seeking behaviors will ensure cognitively impaired residents do not leave the facility unsupervised. Alleged date of immediate jeopardy removal: 5/01/25 A validation of immediate jeopardy removal was conducted on 05/05/24. In-service records and interviews with staff across all departments revealed they had been educated on ensuring safety with smoking and with residents that exhibit wandering or exit seeking behaviors. Staff were also educated on the smoking and wandering binders kept at each nurse's station with the list of resident names, updated assessments, and the policies and procedures. Staff were made aware to notify their supervisor or administrative staff if they observe any changes with residents' behaviors or any safety issue incidents. Front door locks at 5:00 PM and use of pin pad code would be needed to enter and exit after 5:00 PM. Staff were also made aware of where their residents are and completing rounds on residents who are sitting outside on the front porch. Licensed nursing staff were educated on completing accurate smoking	F 689		

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F 689	Continued From page 61 and wandering assessments by reviewing previous assessments, MDS, care plans, progress notes, and completing accurate observations of residents. Interviews with the administrative staff revealed they had been educated to make sure all residents have updated, and accurate mental status completed, and staff were also completing accurate, updated smoking and wandering assessments. Any changes in condition or new behaviors pertaining to smoking or wandering residents were being documented and supervisors were made aware. All smoking and wandering binders were kept up to date with the status of each of the residents. Administrative staff were also completing the education, audits, and monitoring of staff to ensure residents' safety. Observations included residents smoking supervised by staff during designated smoking times wearing designated smoking aprons with no issues noted. Located at each nurse's desk were smoking binders that contained a list of supervised and unsupervised residents, the smoking policy, updated resident smoking assessments, and wandering binders that contained a list of names and pictures of any residents with wandering behaviors or who require wandering devices, along with the wandering policy and protocols. The facility's QA committee met on 4/30/25 and conducted a root cause analysis which was reviewed as part of the removal process. Audits were reviewed with no issues. The facility's removal date of 5/01/25 was validated on 5/05/25.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		5/6/25

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F 755	Continued From page 62 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, Pharmacist, and Medical Director interviews, the facility failed to have an effective system in place to ensure a new physician order for an as needed pain medication was available to administer for 1 of 5 residents (Resident #2) reviewed for	F 755	F 755 Pharmacy Records 1. Resident # 2's discontinued medication was removed from the medication cart on 4/15/25 by the unit manager and returned to the pharmacy	

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F 755	Continued From page 63 pharmacy services. Resident #2 received a new order for her as needed pain medication in January 2025. Resident #2 received seven wrong dosages in March 2025 and two wrong dosages in April 2025 of her as needed pain medication due to the pharmacy not having received the new order from January 2025 and the correct dosages not being sent to the facility. The findings included: Resident #2 was initially admitted to the facility on 2/10/2024 and readmitted from the hospital on 1/13/2025. Resident #2 had diagnoses that included chronic diastolic congestive heart failure, Type 2 diabetes Mellitus with diabetic polyneuropathy (a condition where nerve damage occurs due to persistently high blood sugar levels), intervertebral disc degeneration lumbar region without mention of lumbar back pain or lower extremity pain. Record review indicated Resident #2 resided on the 300-hall during the months of March and April 2025. Resident #2's physician order dated 2/24/2024 prescribed Tramadol HCL Oral Tablet 75 milligrams (mg) (narcotic medication for pain) give one tablet and a half by mouth every 6 hours as needed for pain was discontinued. Resident #2 was transferred to the hospital on 1/10/2025 and admitted with COVID-19 and respiratory failure. Resident #2 was discharged back to the facility on 1/13/2025.	F 755	for appropriate disposal. Provider was made aware on 4/15/25 of doses of discontinued medication administered and provided a new prescription for correct dose of medication that was sent to pharmacy. 2. Director of Nursing, Assistant Director of Nursing and Unit Managers completed 100% audit of all medication carts on 4/15/25 to ensure no discontinued controlled medications were present on the medication carts. No additional findings noted. 3. Education was provided for all licensed staff and medication aides by the Staff Development Coordinator on 4/15/25 regarding the 10 Rights of Medication Administration and removal of discontinued medications from the medication carts. 4. The Director of Nursing or designee will review order listing report for new or discontinued controlled substances, will validate hard script sent to pharmacy for new orders and ensure discontinued controlled substances have been removed from med cart 5 times per week for eight weeks to ensure that discontinued medications are not present on carts. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 5/06/25	

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Resident #2's hospital discharge summary dated 1/13/2025 revealed a new order for Tramadol HCL 50 mg give one tablet by mouth every six hours as needed for pain.

The facility physician order dated 1/13/25 revealed Resident #2 was to receive Tramadol HCL Oral Tablet 50 mg. Give one tablet by mouth every six hours as needed for pain.

Review of Resident #2's tramadol order dated 1/13/2025 indicated the order from the provider was written at 1:32pm by a previous Nurse Practitioner and entered by Nurse #10 on 1/13/2025 at 3:5pm.

Resident #2's Medication Administration Record (MAR) was reviewed from 1/13/2025 through April 2025 and revealed an active order that read Tramadol HCL Oral Tablet 50mg. Give one tablet by mouth every six hours as needed for pain.

During a telephone interview on 4/11/2025 at 5:18 pm Nurse #10 stated she did not remember entering any orders into the electronic medical record for Resident #2 on 1/13/25, but she did remember she verified some orders. Nurse #10 stated orders were entered by the supervisor. Nurse #10 stated she knew narcotic orders had to be faxed from the pharmacy and that when a resident was admitted she would fax the prescriptions that came from the hospital. Nurse #10 was not aware that if a resident had a new order for a different dose of narcotic that a new prescription would have to be sent even though the new order was in the medication profile in the electronic record.

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The 300-hall medication cart controlled medication declining sheet revealed Resident #2 was administered the discontinued dose of Tramadol HCL 75 mg give 1 tablet by mouth every 6 hours as needed on 3/6/2025 (Nurse #11), 3/8/2025, 3/11/2025 (Nurse #6), 3/12/2025, 3/16/2025 (Nurse #7), 3/17/2025, 3/19/2025 (Nurse #6), 4/5/2025 (Nurse #8) and 4/6/2025 (Nurse #9).

Observation of the 300-hall medication cart narcotic box on 4/9/2025 at 5:30pm revealed three blister packs labeled Tramadol HCL for Resident #2 each unpunctured blister contained 75mg of Tramadol HCL.

During a telephone interview on 4/10/2025 at 2:58 pm Nurse #11 stated that maybe she didn't read the label correctly. Nurse #11 stated if she signed that she gave tramadol HCL to Resident #2, then she probably gave the 75mg in the blister pack. Nurse #11 stated she thought the correct dose of medication would be in the narcotic drawer. Nurse #11 documented on 3/6/2025 she administered as needed tramadol HCL to Resident #2.

During an interview on 4/10/2025 at 11:21am Nurse #6 reviewed Residents #2's order on the MAR and Resident #2's controlled medication declining sheet and verified Resident #2 had an order for tramadol HCL 50mg by mouth every 6 hours as needed for pain. Nurse #6 stated she administered tramadol HCL 75 mg to Resident #2 on 3/11/2025 and 3/19/2025.

During a telephone interview on 4/11/2025 at 12:13pm Nurse #7 stated she had been at the facility since July 2023. Nurse #7 stated she did

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not specifically remember if she administered Resident #2 a PRN on 3/16/2025, but if she signed out it was administered then tramadol HCL 75mg was probably administered. Nurse #7 stated if she had wasted the half tablet it would have been signed with another person as wasted. Nurse #7 stated if there are new orders it usually gets reported from shift to shift, and that if a new dosage of a narcotic was ordered a new script would need to be sent to the pharmacy so the medication would be received. Nurse #7 stated you can ask the provider when they are in the facility to write a script or ask the on-call provider to send an electronic script if it is needed. Nurse #7 stated if a new dose of a narcotic is ordered the discontinued dose can be pulled out, signed with a witness and placed in the return bag to be sent back to pharmacy. Nurse #7 stated it was possible since the dosage on the medication blister pack read 50mg, and the instructions above it were smaller, it was possible the wrong dose was administered. Nurse #7 stated third shift returns most of the narcotics, but she knew other nurses were able to send back medications.

During a telephone interview on 4/11/2025 at 12:02pm Nurse #8 stated she was an agency nurse and thought she recalled Resident #2 and had only worked at the facility for one shift on 4/5/2025. Nurse #8 stated if tramadol HCL 75mg was in the blister pack in the medication cart, that is what she administered to Resident #2. Nurse #8 stated she had not received any education regarding returning narcotics to the pharmacy, or that a script was required to receive medication for new narcotic orders.

During a telephone interview on 4/11/2025 at 11:48 am Nurse #9 stated she had worked as an

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agency nurse at the facility off and on since June 2024, and that she worked on different halls. Nurse #9 stated she had not received any education regarding returning narcotics to the pharmacy, and that usually the supervisor on the weekend would take care of sending narcotics back to the pharmacy. Nurse # 9 verified worked with Resident #2 on 4/6/2025 and administered the incorrect dose of tramadol to Resident #2.

During an interview on 4/10/2025 at 10:50am Nurse #5 stated she used to be a unit manager but now worked as a floor nurse. Nurse #5 stated if a provider wrote to change the dosage of a medication a script would need to be sent to pharmacy. Nurse #5 stated if the wrong medication was in the drawer the provider could be notified to see what to administer until the correct medication arrived. Nurse #5 stated she would send back the old dose of medication and make sure the pharmacy had the correct script for the new order.

During an interview on 4/10/2025 at 11:50 am Unit Manager #2 stated she was new to the facility and did not know if a certain shift was responsible for returning discontinued narcotics to the pharmacy. Unit Manager #2 stated if a resident received a new order for a new dose of a narcotic, then she would send back the discontinued dose and request a new dose from the pharmacy.

During an interview on 04/10/25 at 10:14 AM the Unit Manager #1 stated if a resident received an order for a new dose of a narcotic, a new prescription would have to be sent to the pharmacy either faxed by the nurse or sent electronically from the provider.

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During a telephone interview on 4/10/2025 at 10:19 AM Pharmacist #1 stated the pharmacy had not received any requests for tramadol HCL 50 mg for Resident #2. They would need a prescription to dispense and no prescription for tramadol HCL 50 mg had been received for Resident #2. Pharmacist #1 verified tramadol HCL 50 mg was active in Resident #2's medication profile in the electronic health record. Pharmacist #1 stated she was not familiar with the facility's policy on sending back narcotics when there was a dose change, or if they would continue to use the old pack and waste the extra medication. Pharmacist #1 stated if a new script had been sent for tramadol HCL 50 mg, a new blister pack would have been sent.

The Medical Director was interviewed on 4/10/2025 at 12:37 pm and stated he expected discontinued medications to be sent back to the pharmacy and to send in an order to receive blister packs with the correct dosage. The Medical Director expected residents to receive their medications as ordered.

During an interview on 4/10/2025 at 11:57 am the Director of Nursing (DON) verified Resident #2 had an active order for tramadol HCL 50 mg one tab by mouth every 6 hours as needed for pain, written on 1/13/2025, and that Resident #2's medication blister packs of tramadol HCL contained 75 mg in each blister pack. The DON verified a new prescription for Tramadol HCL 50mg should have been sent to the pharmacy on 1/13/2025 so Resident #2's new dosage of Tramadol HCL would be sent to the facility. The DON stated when a new order for a narcotic was received normally a written prescription would be

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F 755	Continued From page 69 faxed to the pharmacy by the nurse, or the provider would send an electronic prescription. During an interview on 4/10/2025 at 3:30pm the Administrator stated she expected a resident's medication to be available and administered as ordered. The Administrator stated she would expect staff to document accurately and honestly on the Medication Administration Record.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, Pharmacist, and Medical Director interviews the facility failed to prevent a significant medication error when scheduled pain medications were not administered as ordered by the physician for 1 of 3 residents (Resident #112) reviewed for assuring facility was free from significant medication errors. Resident #112 was ordered to receive a scheduled pain medication three times a day and failed to receive seven dosages of his scheduled pain medication due to the medication not being available at the facility. The findings included: Resident #112 was admitted to the facility on 12/18/23 with a readmission on 3/03/25. Diagnosis included chronic pancreatitis, severe chronic kidney disease, and chronic pain. Review of the quarterly Minimum Data Set (MDS)	F 760	F 760 Medication Errors 1. Director of Nursing completed pain assessment for Resident # 112 on 4/15/25, mild pain was noted and was within the resident's acceptable pain level threshold. On 4/15/25 the provider was made aware by Director of Nursing of residents missed doses of scheduled pain medication with no new orders, Unit manager validated that medication was present on med cart. On 4/29/25 a new prescription was written by Nurse Practitioner and sent to pharmacy for a greater quantity of the medication. 2. Director of Nursing, Assistant Director of Nursing and Unit Managers completed audit of medication administration record on 4/15/25 for the last 15 days for any scheduled pain medications documented	5/6/25

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F 760	Continued From page 70 assessment dated 3/07/25 revealed Resident #112 was cognitively intact and was also coded for pain and receiving pain medication. Review of revised care plan dated 3/07/25 revealed goal for Resident #112 to be free of signs of pain or complaints of pain and will state relief of pain daily. Interventions included administer pain medications for pain, observe for effectiveness/side effects and reporting ineffectiveness to physician. Review of the Physician order dated 3/03/25 stated to administer Morphine Sulfate (MS) Contin Oral Tablet Extended Release (ER) 30 milligrams (MG) by mouth three times a day for pain. (narcotic analgesic that releases slowly over 12 hours) Review of the Medication Administration Record (MAR) for March 2025 revealed MS Contin Oral Tablet ER 30MG three times daily (8:00 AM, 1:00 PM, 8:00 PM) was coded as not available to be administered to Resident #112 as scheduled on 3/10/25 at 8:00 PM and 3/31/25 at 1:00 PM and 8:00 PM. Review of Nursing Note written by Nurse #18 dated 3/10/25 at 8:00 PM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet three times a day for pain, was on order and was not available to administer. Review of nursing progress note written by Nurse #16 dated 3/31/25 at 1:00 PM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain medication was not available to administer. Resident #112 was still in pain and administered	F 760	as not available. Pain assessment completed on all residents identified as missing a dose of medication on 4/15/25, all residents assessed had no complaints of pain above acceptable threshold. DON, ADON, UMs audited all medication carts on 4/15/25 for presence of scheduled pain medications, no findings noted. 3. Education was provided for all licensed nurses and medication aides by the Staff Development Coordinator on 4/15/25 regarding the process of reordering controlled medications, obtaining hard script, sending prescription to pharmacy and pulling medication from back up stock as needed. 4. The Director of Nursing or designee will review Medication Administration Audit report for any scheduled pain medications not available 5 times per week for eight weeks to ensure doses of scheduled pain medication are not missed. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 5/06/25	

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as needed pain medication.

A telephone interview with Nurse #16 dated 4/10/25 at 2:15 PM revealed she recalled Resident #112's scheduled pain medication being unavailable to administer during lunchtime on 3/31/25. She stated she did not contact the physician or the pharmacy but believed she did notify the on-coming nurse and documented it in the chart.

Review of nursing progress note written by Medication Aide (MA) #2 dated 3/31/25 at 8:00 PM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain was on order and was not available to administer.

A telephone interview with MA #2 dated 4/10/25 at 3:13 PM revealed she recalled Resident #112's scheduled pain medication being unavailable to administer on the evening of 3/31/25. She stated that she did remember notifying the on-coming nurse of the medication not being available and believed she was able to administer him his as needed pain medication in place of the scheduled pain medication.

Review of the Medication Administration Record (MAR) for April 2025 revealed MS Contin Oral Tablet ER 30MG three times daily (8:00 AM, 1:00 PM, 8:00 PM) was coded as not available to be administered to Resident #112 as scheduled on 4/01/25, 4/02/25, and 4/07/25.

Review of nursing progress note written by Nurse #17 dated 4/01/25 at 8:00 AM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain was not

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available to be administered. Nurse Practitioner was made aware, and medication was enroute per pharmacy. No new orders received.

Review of nursing progress note written by Nurse #17 dated 4/01/25 at 1:00 PM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain was not available to administer. Provider was made aware of Resident #112's missed dose, no new orders were received, and medication would resume once arrived from pharmacy.

A telephone interview with Nurse #17 on 4/10/25 at 2:25 PM Nurse #17 revealed she recalled Resident #112's scheduled pain medication being unavailable to administer during the morning and at lunchtime on 4/01/25. She stated that typically when a resident's medication was unavailable, she would look to see if the pharmacy had been called and if not, she would call them for a refill. Nurse #17 revealed she did not recall if she called pharmacy about Resident #112's medication not being available or if it was already noted the medication was on order. She stated Resident #112 did have an as needed pain medication that was administered in place of his scheduled pain medication and when requested.

Review of nursing progress note written by Nurse Supervisor #1 dated 4/01/25 revealed Resident #112's script for MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain had been sent to the pharmacy would be delivered on next pharmacy run.

An interview was conducted with the Nurse Supervisor #1 on 4/10/25 at 2:58 PM revealed she believed she was notified by Nurse # of

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Resident #112 scheduled pain medication being unavailable to administer. She stated she contacted the pharmacy and sent them a copy of the medication script and the pharmacy notified her that Resident #112's medication would be delivered on the next pharmacy run either later that evening or the following morning.
Review of nursing progress note written by Nurse #20 dated 4/01/25 at 8:00 PM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain was not available to administer.

Attempted interview with Nurse #20 and was unable to contact.

Review of nursing progress note written by Nurse #21 dated 4/02/25 at 8:00 AM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain was not available to be administered.

Attempted interview with Nurse #21 and was unable to contact.

Review of nursing progress note written by Nurse #5 dated 4/02/25 revealed Resident #112's MS Contin Oral Tablet ER 30 MG medication was delivered and available on medication cart. Resume medication as ordered.

An interview was conducted with Nurse #5 on 4/10/25 at 10:20 AM. She stated she was familiar with Resident #112 and his medications. She revealed Resident #112 had missed several doses of his scheduled pain medication due to nursing staff not re-ordering the medication from the pharmacy prior to the last dose. She stated resident medications must be ordered prior to the

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last dosage due to the facility pharmacy being in the eastern part of the state and can take longer for the medication to be delivered. Nurse #5 revealed when a resident's medication runs out the nursing staff are supposed to call the pharmacy and see if they would require a new script or not for reorder, and if a new script was needed then nursing staff would contact the physician to receive the new medication order and send the new order to the pharmacy which can also take time. She stated to her knowledge anytime Resident #112's scheduled medications have not been available he had received his as needed pain medication in place of his scheduled pain medication.

Review of nursing progress note written by Nurse #18 dated 4/07/25 at 8:00 PM revealed Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain was not available to be administered. Awaiting delivery of medication from the pharmacy.

Attempted interview with Nurse #18 and was unable to contact.

An interview conducted with Resident #112 on 4/07/25 at 11:25 AM revealed he had chronic pancreatitis and was ordered to receive scheduled pain medication three times a day for his chronic pain related to his pancreatitis. He stated on several occasions during March and April 2025 he had not received his scheduled pain medication due to the facility running out of the medication and waiting on the pharmacy to deliver. He revealed he did not understand why the facility was not able to keep his scheduled pain medication in stock especially since he has had that prescription for a while. He also revealed

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during the times he did not receive his scheduled pain medication he was administered his as needed pain medication, but that medication was short acting, and he could only receive that medication every 8 hours whereas his scheduled pain medication was long acting, and he was able to receive it three times a day. He revealed when he was able to receive his regular scheduled pain medication as ordered his pain was tolerable, and he would only have to take his as needed pain medications in between his scheduled doses when he absolutely needed to.

An interview was conducted with Resident #112 on 4/09/25 at 2:40 PM revealed he missed his evening dose of his scheduled pain medication on Monday (4/07/25) due to the facility running out of it but the pharmacy was able to send more, and he received his next scheduled dose the following morning. He stated he still did not understand why the facility was not able to keep his scheduled pain medication in stock or why staff did not send in an order to pharmacy when they would see that his medication was low. He revealed he did receive a dose of his as needed pain medication on Monday evening to help with his pain until he could receive his scheduled dose the following morning.

A telephone interview with Pharmacist #1 on 4/09/25 at 4:24 PM revealed she was the pharmacy consultant for the facility. She stated they received a pharmacy re-order for Resident #112's MS Contin Oral Tablet ER 30 MG give 1 tablet by mouth three times a day for pain on 4/01/25 and they delivered 15 pills to the facility during the night of 4/01/25. She also stated they received another re-order for the same medication for Resident #112 on 4/07/25 and

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delivered another 15 pills during the night of 4/07/25. Pharmacist #1 revealed the best practice for the facility would be for the nursing staff to reorder resident medications prior to the residents' last dose so the pharmacy would have the allotted time needed to fill and deliver the residents' medications prior to them running out.

An interview with the Medical Director was conducted on 4/10/25 at 12:07 PM. He stated he was familiar with Resident #112 who suffered from chronic pancreatitis which caused chronic pain. He revealed that the facility should always have resident medications available and should not wait until the last dosage of a medication to re-order especially since they account for resident medications on every shift. The Medical Director stated he would consider Resident #112 missing his scheduled pain medication as a significant medication error due to his pain from his chronic pancreatitis. He revealed Resident #112 does have an order for as needed pain medication to be administered every 8 hours and that should be sufficient to assist with pain.

An interview was conducted with the Director of Nursing (DON) on 4/10/25 at 5:45 PM. She stated she also was not aware of Resident #112 missing is scheduled pain medication due to them not being available. She revealed residents should have their medication available to be administered as ordered. The DON stated nursing staff should be re-ordering resident medications prior to the resident's last dosage to keep from running out, and if nursing staff is not aware of how-to re-order medications or does not have access for re-ordering then they should notify their nursing supervisor so the medication could be ordered in a timely manner.

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F 760	Continued From page 77 An interview with the Administrator was conducted on 4/10/25 at 5:30 PM. She stated she was not aware of Resident #112 missing his scheduled pain medication due to not being available. She revealed the facility should have all resident medications available to be administered as ordered, and nursing staff should be re-ordering resident medications prior to them running out.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		5/6/25

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F 761	Continued From page 78 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff and Medical Director interviews, the facility failed to store a lidded container of prescription topical medicated cream to treat foot pain (Resident #110), a lidded container of topical ointment to treat chest congestion, a lidded tube of topical medicated gel to treat arthritis pain, and a lidded tube of topical anti-itch cream (Resident #13) in a secure locked storage area for 2 of 2 residents observed with medicated creams at the bedside (Resident #110 and Resident #13). The findings included: 1. Resident #110 was admitted to the facility on 4/04/25 with diagnoses including dementia, gout and peripheral vascular disease. The admission Minimum Data Set (MDS) was in progress and no information was available. The baseline care plan dated 4/06/25 revealed Resident #110 had problem areas including impaired cognitive function and activities of daily living self-care performance deficit. The interventions included providing cues, reorientation and supervision as needed, asking yes or no questions to determine needs, and providing limited assistance with dressing, hygiene and grooming. On 4/07/25 at 11:41 AM Resident #110 was observed to have a lidded pump container of prescription medicated cream to treat foot pain on his bedside table. Resident #110 stated he brought the cream from home, and it was prescribed by a physician a long time ago, but he	F 761	F 761 Labeling / Storage of Medications 1. Director of Nursing and Unit Managers removed and stored medications from the bedside of Resident # 110 and Resident #13 on 4/15/25. 2. Director of Nursing, Assistant Director of Nursing, and Unit Managers completed 100% audit of the resident rooms for presences of medications at the bedside on 4/15/25. Additional findings noted, all medications discovered in resident rooms were removed and stored on medication carts on 4/15/25. 3. Staff Development Coordinator educated all staff on 4/15/25 regarding storage of medications, including that medications may not be stored at the bedside unless in locked container with appropriate assessments and orders for the resident indicating need. 4. The Director of Nursing or designee will review 10 residents for completion of Medication Self-Administration Assessments and presence of medications at bedside a week for 4 weeks, then 5 residents a week for 4 week. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 5/6/25	

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did not recall the physician's name. Resident #110 further stated he applied the cream to his left foot as needed to help with pain.

An observation of Resident #110's room on 4/09/25 at 2:50 PM revealed the lidded pump container of prescription topical medicated cream to treat foot pain remained on his bedside table.

An interview conducted with Medication Aide #1 (MA) on 4/09/25 at 2:54 PM revealed she was assigned to Resident #110 on first shift (7:00 am to 3:00 pm) on 4/07/25, 4/08/25 and 4/09/25. MA #1 stated Resident #110 was not able to self-administer medications and did not have an order for a medicated foot cream. MA #1 further stated she did not recall observing a container of prescription foot cream on Resident #110's bedside table or anywhere in his room.

During an interview with Nurse #15 on 4/09/25 at 2:57 PM she revealed today was her first day working at the facility and she was the first shift nurse assigned to Resident #110. Nurse #15 stated MA #1 administered most of Resident #110's medications but she did go into his room to administer his morning and afternoon insulin. Nurse #15 indicated while in Resident #110's room she was focused on administering insulin and did not recall observing a prescription foot cream on the bedside table.

During an observation and interview conducted on 4/09/25 at 3:03 PM in Resident #110's room with Unit Manager #3 the lidded container of prescription topical medicated cream to treat foot pain was observed on Resident #110's bedside table. Resident #110 stated to Unit Manager #3 that the medicated cream was prescribed by a

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physician prior to his admission to the facility and he applied at night to help with foot pain. Unit Manager #3 stated there was not an order for the cream and removed it from Resident #110's room. The container had an expiration date of 3/01/25. Unit Manager #3 revealed she was not aware Resident #110 had the medicated foot cream and staff should have been more observant and removed the container of cream from his room.

During an interview with the Medical Director on 4/10/25 at 12:15 PM he stated he did not order the prescription foot cream found in Resident #110's room. The Medical Director indicated Resident #110 was not able to self-administer medications and should not have prescription foot cream in his room.

During an interview with the Director of Nursing on 4/10/25 at 5:43 PM she indicated Resident #110 was not able to self-administer medications, the medicated topical foot cream should not have been in his room and a physician's order should be obtained for all resident medications including topical creams.

An interview conducted with the Administrator on 4/10/25 at 5:40 PM revealed a physician's order should be obtained for all resident medications including topical creams and residents that were unable to self-administer medications should not have medications or topical creams in their room.

2. Resident #13 was admitted to the facility on 1/21/21 with diagnoses which included type 2 diabetes and chronic pain.

Resident #13's quarterly Minimum Data Set

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(MDS) dated 3/28/25 revealed she was cognitively intact requiring extensive assistance of one staff member for most activities of daily living (ADL).

On 4/07/25 at 11:40 AM an observation was conducted of Resident #13's room revealed an open 16-ounce bottle half-full of rubbing alcohol, partially full tube of arthritis 1% medicated gel, two partially full tubes of medicated cortisone cream, 1.76-ounce jar of medicated mentholated vapor rub ointment, and two full tubes of medicated oral pain relief gel located on bedside tray. During the interview with Resident #13 she stated that she used the rubbing alcohol for whatever she needed, arthritis 1% medicated gel for pain in her shoulder, hips, and knees, medicated cortisone cream for rash on her shoulder, medicated mentholated vapor rub ointment on her chest for congestion, and the medicated oral pain relief gel on her gums for discomfort from her teeth. She revealed she was not aware if she had an order to administer the over-the-counter medications herself or not. Resident #13 stated she was not aware if staff knew about her using the over-the-counter medications but that she always kept them on her bedside tray and staff had never asked her about it. She revealed she obtained the over-the-counter medications from her family and friends.

Review of Resident #13's electronic medical chart on 4/07/25 revealed no assessments completed for self-administration of medications or treatments.

On 4/09/25 at 2:30 PM an observation conducted of Resident #13's room revealed the half full

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bottle of rubbing alcohol, two tubes of cortisone cream, jar of vapor rub, and two tubes of oral pain relief gel still located on top of Resident #13's bedside table and the partially full tube of arthritis 1% medicated gel lying on top of Resident #13's lap.

On 4/10/25 at 10:50 AM an observation conducted on Resident #13's room revealed the same half full bottle of rubbing alcohol, two tubes of cortisone cream, jar of vapor rub, two tubes of oral pain relief gel, and the partially full tube of arthritis 1% medicated gel still lying on top of Resident #13's bedside tray.

An interview conducted on 4/10/25 at 11:38 AM with Nurse #5 revealed she was familiar with Resident #13. She stated she was not aware of Resident #13 having over-the-counter medication in her room on her bedside tray or that she was self-administering her own over-the-counter medications. She revealed she had seen items on Resident #13 bedside tray but had never paid attention to what all the items were. Nurse #5 stated to her knowledge no resident was to be in possession of any over-the-counter medications or treatments or allowed to self-administer any over-the-counter medications or treatments without a physician order.

A telephone interview was conducted on 4/10/25 at 2:25 PM with Nurse #17 revealed she was familiar with Resident #13. She stated she was not aware Resident #13 had any over-the-counter medications or treatments in her room and had never seen Resident #13 self-administering any over-the-counter medications or treatments. She revealed she did not recall ever seeing Resident #13 with any over-the-counter medications or

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treatments on her bedside tray but had also never paid close attention. Nurse #17 stated she was not aware of any resident being allowed to keep any over-the-counter medications or treatments in their rooms or allowed to self-administer any over-the-counter medication or treatments without a physician order.

A telephone interview was conducted on 4/10/25 at 3:15 PM with Medication Aide (MA) #2 revealed she was familiar with Resident #13. She stated she was not aware Resident #13 had any over-the-counter medications or treatments in her room and had never seen Resident #13 self-administering any over-the-counter medications or treatments. She revealed she was aware that Resident #13 kept a lot of personal items on her bedside tray but had never paid close enough attention to what those items were. MA #2 stated to her knowledge no resident was allowed to have any over-the-counter medications or treatments in their rooms or allowed to self-administer any over-the-counter medication or treatments without a physician order.

An interview conducted on 4/10/25 at 12:07 PM with the Medical Director revealed he was familiar with Resident #13. He stated he was not aware of Resident #13 having medications or treatments in her room. He revealed no residents at the facility including Resident #13 should have any type of medications, creams, or treatments at bedside. The Medical Director stated all resident medications including over the counter medications and treatments should be kept on the medication cart, have a physician order and administered by nursing staff. He revealed to his knowledge there were no residents at the facility who had been assessed as being able to

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F 761	Continued From page 84 administer their own medications or treatments. An interview was conducted on 4/10/25 at 5:40 PM with the Director of Nursing (DON) revealed she was not aware Resident #13 had over-the-counter medications in her possession that she was self-administering. She stated Resident #13 should not have those items in her possession to self-administer. The DON stated residents in the facility should not have access to, be in possession of, or self-administering any medications or treatments without a physician order, a completed assessment for self-administration of medications or treatments, and staff should be more observant of any medications or treatments in resident's rooms. An interview was conducted on 4/10/25 at 5:30 PM with the Administrator revealed she was not aware of Resident #13 being in possession of and self-administering her own over-the-counter medications. She stated no resident should have possession of or be self-administering any medication or treatments without a physician order. The Administrator stated she expected staff to be more observant of any medications or treatments located in residents' rooms. She revealed if nursing staff were to find any resident with medications or treatments in their rooms, they should notify their supervisor immediately so the medication or treatment could be removed and the physician notified.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		5/6/25

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

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

§483.70(h)(2) The facility must keep confidential 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

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F 842	Continued From page 86 unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, Physician and staff interviews, the facility failed to maintain a complete and accurate medical record when staff documented on the MAR that a scheduled medication was administered, but it was not signed as administered on the controlled medication declining sheets for 1 of 3 residents reviewed for medications (Resident #2). Findings included: A physician order dated 7/24/2024 read Pregabalin Oral Capsule 200mg (narcotic controlled substance) Give one capsule by mouth two times a day for Neuropathy. The order was	F 842	F 842 Resident Records 1. Resident # 2 is currently receiving all scheduled medications as ordered. A pain assessment was completed on 4/15/25 for Resident #2 with no pain noted. Provider made aware on 4/15/25 of any missed doses of medication, no new orders noted. 2. A) Director of Nursing and Nursing managers completed 100% audit on 4/15/25 of all declining count sheets to ensure accurate documentation on the Medication Administration Record (MAR).	

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F 842	Continued From page 87 discontinued on 1/10/2025. A physician order dated 1/13/2025 read Pregabalin Oral Capsule 200 mg (narcotic controlled substance) Give one capsule by mouth every 12 hours for pain. Observation on 4/9/2025 at 4:30pm of Resident #2's controlled medication declining sheets indicated Resident #2 had not received doses of pregabalin 200mg on the following: 10/20/2024 at 4:00pm 2/27/2025 at 9:00am 3/6/2025 at 9:00pm 3/18/2025 at 9:00am 3/27/2025 at 9:00am Review of Resident #2's Medication Administration Record (MAR) indicated the following: On 10/20/2024 at 4:00pm pregabalin 200mg was signed as administered by Nurse #10 On 2/27/2025 at 9:00am pregabalin 200mg was signed as administered by Nurse #14 On 3/6/2024 at 9:00pm pregabalin 200mg was signed as administered by Nurse #19 On 3/18/2024 at 9:00am pregabalin 200mg was signed as administered by Nurse #1 On 3/27/2024 at 9:00am pregabalin 200mg was	F 842	Provider was notified of any negative findings on 4/15/25 by Director of Nursing with no new orders. 3. Education was provided on 4/15/25 to Licensed Nurses and Medication Aides by the Staff Development Coordinator on ensuring accurate documentation upon administration of controlled medications on declining count sheet as well as MAR. 4. Director of Nursing and/or Assistant Director of Nursing to audit 5 declining count sheets 5 days a week X 4 weeks then 10 declining count sheets weekly X 4 weeks to ensure declining count sheet reflects MAR documentation. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 5/6/25	

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signed as administered by Medication Aide (MA) #2

During a telephone interview on 4/11/2025 at 10:11am Nurse #1 stated she had been agency for a year but just signed on as a fulltime staff at the facility. Nurse #1 stated she would agree that she had not administered pregabalin if the narcotic count was correct and she had not signed it out on the narcotic declining inventory sheet.

During a telephone interview on 4/11/2025 at 5:18pm Nurse #10 stated if she had signed a med was administered on the MAR, but not on the controlled medication declining count sheets, and the count was correct, then she probably did not administer the medication.

During an interview on 4/10/2025 at 3:10pm MA #2 verified that she worked on 3/27/2025 and did not administer pregabalin 200mg to Resident #2 at 9:00am even though it was signed on the MAR. MA #2 stated she normally works on second shift but came in early to help that day and must have just missed it by accident.

During an interview on 4/10/2025 at 11:57am the Director of Nursing (DON) stated administered narcotic medication should be documented on the controlled narcotic declining count sheets and the MAR.

The Medical Director (MD) was interviewed on 4/10/2025 at 12:37pm and stated he expected staff to document accurately and honestly on the MAR and narcotic record.

During an interview on 4/10/2025 the

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F 842	Continued From page 89 Administrator stated she would expect a resident to receive medication as ordered. The Administrator stated she would expect staff to document accurately and honestly on the MAR.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F 880		5/6/25

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F 880	Continued From page 90 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when Unit Manager #2 did not perform hand hygiene before donning clean gloves while providing suprapubic	F 880	FTAG 880 Unit manager doffed her gloves and without sanitizing her hands, donned new gloves and proceeded to apply split gauze dressing around the catheter site and	

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F 880	Continued From page 91 catheter care to Resident #83. This deficient practice occurred for 1 of 6 staff members observed for infection control practices (Unit Manager #2). The findings included: Review of the facility's policy entitled Handwashing/Hand Hygiene last updated October 2023 read in part: Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Indications for Hand Hygiene 1. Hand hygiene is indicated: b. Before performing as aseptic task; c. After contact with blood, body fluids or contaminated surfaces; f. Before moving from work on a soiled body site to a clean body site on the same resident; and g.Immediately after glove removal 2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations. 5. The use of gloves does not replace hand washing/hand hygiene. An observation of Unit Manager #2 providing suprapubic catheter care on Resident #83 was made on 04/09/25 at 2:25 PM. Unit Manager #2 had her supplies laid out on the overbed table. She donned a clean gown and sanitized her hands and donned clean gloves and began cleaning around the catheter site on Resident #83's abdomen with wound cleanser. The area was slightly reddened and Unit Manager #2 stated she would contact the Nurse Practitioner (NP) to get some medicated cream to apply to	F 880	taped it into place. 1. On 4/10/2025, Director of Nursing assessed Resident # 83 Notified MD, no new orders. 2. On 4/10/2025, Director of Nursing Educated Unit Manager on Appropriate Hand Hygiene during wound care. 3. On 4/10/25, Director of Nursing, Assistant Director of Nursing, and unit manager initiated in service education to all licensed nurses regarding general infection control, including hand hygiene after doffing gloves during care, with education to continue upon return to work for all staff and completion by 5/6/2025. Education will be provided to newly hired or contracted nursing staff by the director of nursing or infection preventionist upon high prior to receiving an assignment. 4. The Director or Nursing, Assistant Director of Nursing and Unit Manager, will monitor 5 staff members weekly X 8 weeks to ensure appropriate Hand Hygiene, then 5 staff members monthly x 3 months to ensure appropriate Hand Hygiene. The Facility Administrator and /or DON will report Results of these audits, and they will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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the reddened area. Unit Manager #2 finished cleaning the area from the inside outward and took a dry gauze and began to pat it dry. She doffed her gloves and without sanitizing her hands, donned new gloves and proceeded to apply a split gauze dressing around the catheter site and taped it into place. Unit Manager #2 then assisted Nurse Aide (NA) #1 with changing the resident's brief, gathered her supplies and trash, doffed her gown and gloves, sanitized her hands and left the room.

An interview on 04/10/25 at 1:14 PM with Unit Manager #2 revealed she realized afterwards that she had forgotten to sanitize her hands after doffing her gloves and before applying clean gloves. She stated it was an oversight and that she knew she should have sanitized her hands before donning clean gloves.

An interview on 04/10/25 at 1:27 PM with the Infection Preventionist (IP) revealed Unit Manager #2 should have sanitized her hands after doffing her gloves and before donning clean gloves to apply Resident #83's dressing.

An interview on 04/10/25 at 5:07 PM with the Director of Nursing and Administrator revealed they expected Unit Manager #2 to follow the Handwashing/Hand Hygiene policy and procedure when providing care to the residents.