STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 03/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL ELIZABETH CITY LLC	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

(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 survey and complaint investigation was conducted from 3/27/22 through 3/30/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #I6B811.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted from 3/27/22 through 3/30/22. Event ID# I6B811. 4 of the 28 allegations were substantiated resulting in deficiencies. Intake #'s: NC00187496, NC00187409, NC00187059, NC0018298, NC00185604, NC00186105, NC00184812, NC00182433, NC00181108, NC00183712.	F 000		
F 567 SS=C	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in	F 567		4/27/22

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

Electronically Signed | 04/25/2022

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F 567	Continued From page 1 an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to provide access to personal funds accounts on evenings or weekends for 2 of 3 residents reviewed for personal funds. (Residents #32 and #39). Findings included: (1) Resident #39 was admitted to the facility on 5/31/18. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 2/10/22 revealed Resident #39 was cognitively intact. During an interview on 3/27/22 at 11:12 AM Resident #39 revealed the facility managed her	F 567	F 567 Resident #32 and Resident #39 will continue to have personal funds available during business hours and after hours and on weekends. On 3.28.22 the Business Office Manager (BOM) provided lockbox with $100 petty cash to licensed charge nurse to store and maintain on designated medication cart and residents were made aware of after hour resident fund availability by the Assistant BOM. On or before May 10, 2022 the Business office manager and Activities Director educated residents on the 24 hours a day seven days a week.	

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F 567	Continued From page 2	F 567		

funds and she was not able to obtain money on the weekends.

(2) Resident #32 was admitted to the facility on 10/3/21.

Record review of the MDS Quarterly Assessment dated 2/02/22 revealed Resident #32 was cognitively intact.

During an interview on 3/27/22 at 11:43 AM Resident #32 revealed the facility managed her funds and she was not able to obtain money in the evening or on the weekends because there was no one to handle the money.

During an interview on 3/28/22 at 1:49 PM the Assistant Business Office Manager (ABOM) revealed that Residents were to have access to their funds 7 days a week. She stated the person that distributes the funds did not work on the weekends, so the residents were unable to access their money 7 days a week.

During an interview on 3/28/22 at 2:02 PM the Business Office Assistant revealed she worked Monday thru Friday and the residents did not have access to their money on Saturday or Sunday.

During an interview on 3/29/22 the Business Office Manager (BOM) revealed she was a new hire and was notified that the Residents did not have access to their funds as required. The BOM stated the facility would have a money box available for residents to access their funds when the Business Office was closed.

During an interview on 3/30/22 at 5:20 PM the

Availability. After-hour cash disbursement record keeping will be maintained via disbursement slips which will be available in lockbox for nursing documentation. Resident funds will be available by the BOM Monday-Friday 9:00am-5:00pm and by the charge nurse after 5:00pm, Monday through Friday and 24/7 on weekends. The admission's coordinator/designee will review with resident and or responsible party during the admission process the availability of patient trust funds availability.

On or before May 10, 2022, all current licensed nurses, agency licensed nurses and medication aides received education on maintaining a designated lockbox stored on the medication cart, disbursing and record-keeping of resident personal funds after hours and on weekends. After-hour cash disbursement record keeping will be maintained via disbursement slips which will be available in lockbox for nursing record-keeping. Shift-to-shift counting of funds will be completed and any inaccuracies will be reported immediately to the Director of Nursing. The Assistant BOM will replenish the funds and disbursement slips and reconcile funds in lockbox each weekday.

The Administrator or Director of Nursing will monitor 24/7 availability and accurate record keeping of resident personal funds weekly for four weeks and then monthly for two more months and report findings to the QAPI Committee monthly. Changes will be made to the plan as necessary to

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F 567	Continued From page 3 Regional Director of Clinical Services revealed the Residents were expected to have access to their money 7 days per week.	F 567	maintain compliance with resident funds. Completion date: 5/10/22	
F 568 SS=C	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record reviews, Resident and staff interviews, the facility failed to provide 3 of 3 Residents (Resident #32, #56, #39) with quaterly statements of their personal trust fund account managed by the facility reviewed for personal funds. The findings included: Resident #56 was admitted to the facility on 12/1/14. ,The Minimum Data Set Assessment completed on 3/10/22 indicated Resident #56 was cognitively intact. The electronic medical record indicated Resident	F 568	F 568 1. On or before 5/10 /22 Residents#32, #56 and #39 were provided with a current statement of available trust funds and informed that on demand statements may be requested during regular business hours Monday through Friday 9am-5pm. 2. On or before 5/10/22 the assistant Business Office Manager (BOM) hand-delivered current quarterly statements (January 2022-March 2022) to current cognitively intact residents with trust accounts. The BOM mailed to the resident representatives for cognitively impaired residents. Next quarterly	5/10/22

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F 568	Continued From page 4 #56 was her own responsible party. An interview completed with Resident #56 on 3/28/22 at 8:45am revealed she had a personal funds account at the facility. An interview was completed with Assistant Business Office Manager (ABOM) on 3/28/22 at 1:49pm. She indicated personal fund statements were normally available and distributed at the beginning of each month. But due to the intermittent turnover of the Business Office Manager position over the last several months, the personal fund statements were not sent out. An interview was completed with the Business Office Manager (BOM) on 3/29/22 at 10:18am. She stated she was newly hired to the facility and recently made aware Residents had not received their personal fund statements. She indicated statements should have been given to Residents or their responsible parties monthly. The BOM further stated she was printing personal fund statements this week and distributing them to the Residents or their responsible parties. A follow up interview was completed with Resident #56 on 3/30/22 at 9:07am. She stated she was unable to recall when she had last received a financial statement indicating the amount in her personal funds account. Resident #56 revealed she had not received one since last year. An interview was completed with the Regional Director of Clinical Services on 3/30/22 at 5:20pm. She stated it was her expectation Residents received personal fund statements at least quarterly.	F 568	statement will be mailed for (April, May, June) in July 2022. 3. On or before 5/10/22, all current business office staff including the BOM received education by the Administrator on resident rights and process of ensuring cognitively intact residents with trust accounts receive written quarterly statements with signed resident acknowledgment and statements are mailed to resident representatives for cognitively impaired residents. Education included residents right to request on demand statements of resident trust funds during regular business hours Monday through Friday 9am-5pm. Newly hired business office staff will receive education during the orientation process. 4. Administrator or designee will monitor timely delivery of all quarterly trust fund statements and will review resident fund management service statement distribution log monthly with business office manager. The administrator will conduct random resident□s interview with 5 residents weekly for 12 weeks to cognitively intact residents to verify on-demand statements are being provided when requested. Administrator will report findings to the QAPI Committee for review. Changes will be made to the plan as necessary to maintain compliance with resident trust funds. 5. Completion date: May 10, 2022	

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F 568	Continued From page 5	F 568		

Findings included:

(2) Resident #39 was admitted to the facility on 5/31/18.

Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 2/10/22 revealed Resident #39 was cognitively intact.

During an interview on 3/27/22 at 11:12 AM Resident #39 revealed the facility managed her funds and she had not received a statement from the facility and was not aware of her account balance. She stated she was unable to remember the last time she received a personal funds statement from the facility.

(3) Resident #32 was admitted to the facility on 10/3/21.

Record review of the MDS Quarterly Assessment dated 2/02/22 revealed Resident #32 was cognitively intact.

During an interview on 3/27/22 at 11:43 AM Resident #32 revealed the facility managed her funds and had not provided a statement for some time. She was unable to remember the last time she had received a statement from the facility.

During an interview on 3/28/22 at 1:49 PM the Assistant Business Office Manager (ABOM) revealed that personal fund statements were distributed to the Residents at the beginning of the month. She stated the distribution of the statements had not occurred for several months due to turnover in the Business Office. The ABOM stated she had access to the Resident

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F 568	Continued From page 6 Fund Management System (RFMS), but she did not print or deliver the statements to the residents because she worked in multiple roles during that time and was unable to manage the personal funds statements. During an interview on 3/29/22 at 10:18 AM the Business Office Manager (BOM) revealed she was new to the position and was notified that the personal funds statements had not be distributed as required. She stated the ABOM had access to the RFMS account and was able to distribute to the Residents. During an interview on 3/30/22 at 5:20 PM the Regional Director of Clinical Services revealed Resident statements were expected to be distributed timely.	F 568		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576		5/10/22

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F 576	Continued From page 7 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail to residents on Saturdays for 2 of 2 residents reviewed for mail delivery. (Resident #28 and #39). Findings included: (1) Resident #28 was admitted to the facility on 3/19/21. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 1/31/22 revealed Resident #28 was cognitively intact. During an interview on 3/29/22 at 1:30 PM Resident #28 revealed the facility did not deliver	F 576	F 576 Residents #28 and #39 will continue to receive mail upon delivery, including Saturdays. On or before May 10, 2022, the weekend receptionist will observe for postal delivery on Saturday to the outside locked mailbox. The receptionist will retrieve mailbox key from 100 hall med cart petty cash box, sign for the key, collect the mail, sort the mail for Greeting cards and parcels for current residents and deliver them. The mailbox key will be returned to the designated petty cash box, and	

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F 576	Continued From page 8 mail on Saturdays. (2) Resident #39 was admitted to the facility on 5/31/18. Record review of the MDS Quarterly Assessment dated 2/10/22 revealed Resident #39 was cognitively intact. During an interview on 3/29/22 at 1:30 PM Resident #39 revealed the facility did not deliver mail on Saturdays. During an interview on 3/29/22 at 4:47 PM the Activities Director revealed the front office managed mail delivery to the Residents. During an interview on 3/29/22 at 5:05 PM the Business Office Assistant revealed she was responsible to deliver mail to the Residents. She stated she worked Monday thru Friday and there was no one to deliver the mail when she was not scheduled. She stated when the mail was delivered on Saturday, she would deliver the mail to the Residents on Monday when she returned to work. During an interview on 3/30/22 at 5:02 PM the Regional Director of Clinical Services revealed the mail was expected to be delivered to the Residents on Saturday.	F 576	remaining mail will be locked in the medication room by the charge nurse until retrieved by the business office manager on the next office day. On or before May 10, 2022, the Administrator provided education to weekend receptionist and manager on duty for Saturday and Sundays on the new practice for weekend mail delivery. The weekend receptionist will observe for postal delivery on Saturdays until 5:00pm. When postal services deliver mail to the facility after 5:00pm the mail will be distributed the next day by the receptionist or manager on duty. Cognitively and intact residents will be educated on the new mail delivery process for the weekend. The admission□s director will review this new process with new resident during the admission process. New receptionist and department managers will be educated on the new process during orientation. Administrator or designee will monitor for Saturday delivery weekly for four weeks then, monthly for two months and report findings to the QAPI Committee for review and correction as needed. Completion Date: May 10, 2022	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		5/10/22

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F 580	Continued From page 9	F 580		

consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in

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F 580	Continued From page 10 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Physician interviews the facility failed to notify the physician/medical director when 2 medications were not available in the facility for a resident during the first 24 hours of admission for 1 of 2 residents (Resident #58) reviewed for changes. Findings included: Resident #58 was admitted to the facility on 12/31/21 and discharged on 1/1/22 with diagnoses that included left thigh bone fracture, scoliosis, and stroke. A physician order dated 12/31/21 for Methocarbamol (muscle relaxant) 500 milligrams (mg) by mouth 4 times daily for muscle spasms. Another order dated 12/31/21 for Xanax (anti-anxiety) 0.5mg 1 tablet by mouth in the morning for anxiety. On 12/31/21, the physician also ordered Xanax 0.5mg 2 tablets by mouth at bedtime for anxiety. The December 2021 Medication Administration Record (MAR) for Resident #58 revealed the following medications were not administered as ordered on the following dates: - Xanax: 12/31/21 at 9:00 PM - Methocarbamol: 12/31/21 at 12:00 PM - Methocarbamol: 12/31/21 at 5:00 PM - Methocarbamol: 12/31/21 at 9:00 PM	F 580	F-580 1. Resident #58 no longer resides at the facility. On 3/30/22, the Medical Director (MD) and Nurse Practitioner (NP) for resident #58 was notified of the missed medications by the Interim Director of Nursing. No adverse reactions resulted. 2. On or before 5/10/22, the Director of Nursing (DON) and Unit Coordinators reviewed all newly admitted residents from 3/20/22 to 4/4/22 to ensure MD/NP and Resident Representative (RR) notifications had been made regarding any missed medications. Those residents with unknown notification status, MD/NP and RR were notified and documented in the residents medical record. Notification and documentation completed on or before 5/10/22. 3. On or before May 10, 2022, the Director of Nursing and Regional Nurse Consultant educated all current facility and agency licensed nurses on notifying the MD/NP and RP of changes in resident condition including missed medications per physician order. Newly hired licensed nurses and agency nurses will receive education prior to working or as part of the orientation process. The Director of	

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F 580	Continued From page 11 The January 2022 MAR for Resident #58 revealed the following medications were not administered as ordered on the following dates: - Xanax: 1/1/22 at 9:00 AM - Methocarbamol: 1/1/22 at 9:00 AM - Methocarbamol: 1/1/22 at 12:00 PM During a phone interview with the Medical Director on 3/30/22 at 5:37 PM, he revealed he was not alerted by the facility or pharmacy that Resident #58 was missing medications. He stated he would have intervened if he had been notified. The Regional Director of Clinical Services (RDCS) was interviewed on 3/30/22 at 1:08 PM with the Administrator and Director of Nursing (DON) present. She revealed her expectation was for the physician to be notified when medications were unavailable to administer.	F 580	Nursing will monitor MD/NP and RP notification in the daily morning clinical meetings. 4. Monitoring of MD/NP and RR notifications will be completed by the Director of Nursing or Unit Coordinator for five (5) random residents at a frequency of five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Director of Nursing will report findings of the monitoring to the QAPI committee monthly and will make changes to the plan as necessary to maintain compliance with notification of MD/NP and RP with changes of condition. Completion Date: 5/10/22	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		5/10/22

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	345184	A. BUILDING _____ B. WING _____	C 03/30/2022

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F 584	Continued From page 12 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide a clean and sanitary environment by failing to clean a tube feeding pump and pole for 1 of 1 resident observed with a tube feeding pump and pole (Resident #20). The findings included: On 3/27/22 at 11:44 AM Resident #20 was observed lying in bed and a pole with a tube feeding pump and a bag of milky, beige tube feeding formula was near the head of the	F 584	F-584 1) On 03/30/2022, the housekeeper cleaned the tube feeding pump/pole of resident #20. 2) On 4/4/22, an audit of all feeding poles was conducted by Housekeeping, and they are all without debris and dust and were clean and sanitary. 3) On 3/30/22, the	

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F 584	Continued From page 13 resident's bed. The four legs of the pole were observed to have a milky, beige substance on all four legs of the pole. The bottom of the tube feeding pump was observed to have a beige substance on the bottom of the pump. The housekeeper was observed to be on the hall where the resident resided with her cleaning cart. On 3/30/22 at 12:44 PM a second observation was made of the tube feeding pump and pole. There was a larger amount of a dried milky, beige substance all 4 legs of the pole and there were multiple dried lines of a milky substance observed on the pole below the pump and areas of a dried milky, beige substance on the front and bottom of the tube feeding pump. On 3/30/22 at 12:44 PM an interview was conducted with the Environmental Services Director (ESD) who stated that housekeeping was responsible for cleaning the tube feeding poles/pumps. An observation of the tube feeding pump was made with the (ESD) who stated she would have the pole and pump cleaned right away. On 3/30/22 at 12:49 PM an observation of the pump/pole in Resident 20's room was made with the Director of Nursing (DON). The DON stated she was new and did not know this facility's protocol for cleaning tube feeding pumps/poles, but anyone could clean a tube feeding pump/pole and she would make sure that it was cleaned. On 3/30/22 at 1:16 PM an interview was conducted with the Regional Director of Clinical Services and the DON. The Regional Director stated that housekeeping should develop a	F 584	Administrator/designee reeducated the Housekeeping Manger and then the Housekeeping Manager reeducated housekeepers by 4/22/22 on maintaining tube feeding pumps/poles in clean and sanitary condition. A cleaning schedule was established for resident with feeding poles to ensure resident right to a safe, clean, homelike environment. Newly hired Housekeeping Managers and housekeepers will receive education during orientation. The Housekeeping Manager will maintain a weekly cleaning schedule for tube feeding poles. 4) Administrator/Designee will complete observation monitoring of 3 residents with feeding tubes for cleanliness and sanitation. Audits will be completed twice weekly for 12 weeks, and results of monitoring will be discussed by the Administrator during monthly Quality Assurance Process Improvement (QAPI)meetings. Changes will be made to the plan as necessary to maintain compliance with resident right to safe, clean homelike environment. 5. Completion Date: May 10, 2022	

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F 584	Continued From page 14 schedule for cleaning tube feeding poles.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to 1) implement their abuse policy and procedures in the area of providing complete and thorough documentation and 2) submit the 5-day investigation report to the state agency within 5 business days for 1 of 3 investigations reviewed for abuse. Findings included: A review of the facility policy and procedure titled "Abuse, Neglect, and Exploitation" dated 11/1/20, read in part: Written Procedures for investigations include: 6) Providing complete and thorough documentation of the investigation. Resident #28 was readmitted to the facility on 3/19/21 with diagnoses that included anxiety and depression. Her quarterly Minimum Data Set	F 607	F-607 1) The resident-to-resident incident involving Resident # 28 and Resident #56 final investigation was reported to the NC State Agency on 10/26/21 by the Administrator outside the 5-day window. 2) On 4/4/22, the Regional Director of Clinical Services completed an audit of reported abuse incidents from 3/1/22-4/1/22 to ensure all reported allegations of abuse final investigations were reported timely within the 5-day timeframe to NC state agency and consisted of documentation reflecting a comprehensive investigation. No additional abuse incidents were identified as not being reporting timely or having a comprehensive investigation.	5/10/22

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F 607	Continued From page 15 (MDS) assessment dated 10/29/21 indicated she was cognitively intact. Resident #56 was readmitted to the facility on 2/24/22 with diagnoses that included anxiety and depression. Her quarterly Minimum Data Set (MDS) assessment dated 13/2/21 indicated she was cognitively intact. A nursing progress note dated 10/4/21 was reviewed and revealed the Social Worker (SW) was informed Resident #28 and Resident #56 were fighting. When she arrived at their room, she was notified Resident #56 struck Resident #28 with her hand and continued to shake Resident #28's footboard. Resident #28 was crying and asked to move rooms. Review of the initial allegation report dated 10/4/21 revealed Resident #28 stated her roommate, Resident #56, hit her on the foot. Review of the investigation report dated 10/26/21 completed by the Administrator at the time revealed all documentation for staff interviews, behavior tracking for Resident #28 and Resident #56, and pharmacy medication review for Resident #28 were not available at the time of the survey. The report also revealed it was submitted 15 days late to state authorities. An interview was conducted with the Regional Director of Clinical Services (RDCS) on 3/30/22 at 12:48 PM with the current Administrator and Director of Nursing present. She revealed her expectation was that she and her team would have completed thorough documentation of the investigation of abuse between Resident #28 and Resident #56. She stated she completed the	F 607	3) On 4/7/22, the current Administrator was educated by the Regional Director of Clinical Services on the timely reporting of the final investigation findings of abuse allegations of 5 days to NC state agency per facility Abuse and Neglect policy and F 607 regulation. The newly hired Administrators has received education on 4.25.22 during the orientation process and prior to working. Newly hire administrators will receive education during the orientation process and prior to working. The Administrator is the designated Abuse Coordinator and will be responsible for the timely reporting to NC state agencies for all allegations of abuse. 4) The regional nurse consultant will monitor final investigations findings of Abuse reportable to ensure timely reporting of the final 5-day investigations to NC state agency. Monitoring will be completed 1X week for 4weeks and 1X a month for 2 months as needed to ensure compliance. The Administrator will review results of monitoring with the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance. 5) Completion Date: May 10, 2022	

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F 607	Continued From page 16 initial allegation report and left the documentation of the investigation in a folder for the previous Administrator but had not seen the documentation since then. The RDCS further stated her expectation was the 5-day investigation report should have been submitted according to the time requirements. She stated she was not aware the 5-day investigation was reported late until the state agency contacted her via telephone (date unknown).	F 607		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		5/10/22

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F 623	Continued From page 17	F 623		

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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F 623	Continued From page 18 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a written notice of the reason for discharge to the resident and/or Responsible Party (RP) for 2 of 2 residents reviewed for hospitalization. (Residents #40 and #58). The findings included:	F 623	F-623 1. Notification with reason for discharge was provided to resident #40 and his Resident Representative (RR) on or before 5/10/22 who was affected by not being provided written notification of discharge. The identified resident #58 and his responsible party were unable to	

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F 623	Continued From page 19 1. Resident #40 was admitted to the facility on 2/11/22. The Admission Minimum Data Set (MDS) Assessment dated 2/17/22 noted the Resident was cognitively intact. On 2/21/22 Resident #40 was discharged to the hospital and was re-admitted to the facility on 2/24/22. On 3/30/22 at 2:30 PM an interview was conducted with Social Worker #1 and the Regional Director for Clinical Services. Social Worker #1 stated they sent a bed hold policy with the resident to the hospital and called the Responsible Party (RP) and let them know the resident was going to the hospital but did not send a written notice of the reason for discharge to the Resident or the RP. The Regional Director for Clinical Services stated she was not aware that a written notice of the reason for discharge was required to be sent to the RP and they had not been doing this. 2. Resident # 58 was admitted to the facility on 2/23/22. On 3/15/22 Resident #58 was discharged to the hospital on 3/15/22 and the resident did not return to the facility. The Admission Minimum Data Set (MDS) dated 2/28/22 revealed the Resident had severe cognitive impairment. On 3/30/22 at 2:30 PM an interview was conducted with Social Worker #1 and the	F 623	be notified as resident no longer resides at the facility. 2. The Regional Director of Nursing and Social Worker completed an audit of residents discharged from the facility from 3/20/22-4/20/22 to review written notifications to resident, resident representative, and Ombudsman with reason for discharge on or before May 10, 2022, for those identified. 3. On or before 5/10/2022 education on the written notification of discharge policy was provided to all licensed nursing staff, licensed agency nurses. Admissions Director, Director of Nursing, Administrator and Social Worker by the Regional Director of Clinical Services of the Nursing. Education included the process of the Social Worker, Director of Nursing, Administrator or nurse. The licensed nurse, social worker, administrator, director of nursing or designee will be responsible for providing notice to the resident and resident representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Additionally, a copy of the notice will be provided to a representative of the Office of the State Long-Term Care Ombudsman. All newly hired facility and agency licensed nurses, Admission Directors and Social Services will receive education prior to working as part of the orientation process. 4. Ongoing audits by the Administrator or	

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F 623	Continued From page 20 Regional Director for Clinical Services. Social Worker #1 stated they sent a bed hold policy with the resident to the hospital and called the Responsible Party (RP) and let them know the resident was going to the hospital but did not send a written notice of the reason for discharge to the RP. The Regional Director for Clinical Services stated she was not aware that a written notice of the reason for discharge was required to be sent to the RP and they had not been doing this.	F 623	Director of Nursing for observation and review of proper execution of written notification of discharge. Audits will be conducted three (3) times weekly for eight (8) weeks then weekly for four (4) weeks. These audits will include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility QAPI meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance with discharge and transfer notification. 5. Completion Date: May 10, 2022	
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	F 644		5/10/22

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F 644	Continued From page 21 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 refer residents with newly evident serious mental health diagnoses for a Preadmission Screening and Annual Resident Review (PASARR) level II screen for 2 of 2 residents reviewed for PASARR. (Residents #5 and #25). Findings included: 1. Resident #5 was admitted to the facility on 2/06/19 with diagnoses which included dementia, psychosis, and anxiety. Record review of the Minimum Data Set (MDS) Annual Assessment dated 1/2/22 revealed Resident #5 was cognitively intact and did not have a PASARR Level II. Resident #5 was coded for verbal behaviors which included threatening, yelling, and cursing at others. Resident #5 ' s diagnoses included anxiety disorder, depression, and psychotic disorder. Record review of Resident #5 ' s diagnosis list revealed a new mental health diagnosis of schizoaffective disorder was added 1/17/22. During an interview on 3/28/22 at 3:21 PM Social Worker (SW) #1 revealed that she was unsure if a new screening was required with the addition of the new mental health diagnosis for Resident #5. The SW confirmed Resident #5 ' s schizoaffective disorder diagnosis was a new diagnosis during her stay, and she was not referred for a PASARR Level II screen.	F 644	F644 1. The Social Worker completed a Preadmission Screening and Annual Resident Review (PASARR) for Resident #5 and #25 for level II status on 4.27.22 2. On or before 5/10/22 the Social Worker completed an audit of all current residents for accurate PASARR level status and submitted a Preadmission Screening and Annual Resident Review (PASARR) level II screening for any resident with a new serious mental health diagnosis. Social worker will review new admissions PASARR to ensure appropriate level status. 3. On 4/25/22, the Social Worker was in-serviced by the Administrator on the process for completing a level II PASARR review for residents with a new serious mental health diagnosis. Newly hired Social Workers will be educated during the orientation process. 4. The Administrator or Director of Nursing will review 5 random residents for accurate PASARR level, including level II screening for residents with a new serious mental health diagnosis. Audits will be completed weekly for three (3) months and findings reported to the QAPI Committee monthly. Changes will be made to the plan as necessary to maintain compliance with PASARR	

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F 644	Continued From page 22 During an interview on 3/28/22 at 4:20 PM the Regional Director of Clinical Services revealed any resident with a newly evident serious mental health diagnosis was required to be referred to PASARR for a level II screen. 2. Resident #25 was admitted to the facility on 7/09/20 with diagnoses which included depression. Record review of Resident #25 ' s diagnosis list revealed new serious mental health diagnoses of bipolar disorder dated 1/8/21, schizoaffective disorder dated 6/16/21, major depressive disorder dated 1/17/22, and delusional disorder dated 1/17/22. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 1/24/22 revealed Resident #25 was cognitively intact and did not have a PASARR Level II. She was coded for behaviors which included screaming and cursing at others. Resident #25 ' s diagnoses included depression, manic depression, psychotic disorder, and schizophrenia. During an interview on 3/28/22 at 3:21 PM Social Worker (SW) #1 revealed that she was unsure if a new screening was required with the addition of the new mental health diagnoses for Resident #25. The SW confirmed Resident #25 ' s new serious mental health diagnoses of bipolar disorder, schizoaffective disorder, major depressive disorder, and delusional disorder were identified during her stay at the facility, and she was not referred for a PASARR Level II screen. During an interview on 3/28/22 at 4:20 PM the Regional Director of Clinical Services revealed	F 644	screening. 5. Completion Date: May 10, 2022	

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	345184	A. BUILDING _____ B. WING _____	C 03/30/2022

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F 644	Continued From page 23 any resident with a newly evident serious mental health diagnosis was required to be referred to PASARR for a level II screen.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		5/10/22

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F 656	Continued From page 24 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to implement a communication deficit care plan for 1 of 23 residents reviewed for care plans (Resident #33) and failed to care plan a resident's urinary catheter for 1 of 3 residents reviewed for urinary catheters (Resident #40). The findings included: 1. Resident #33 was admitted to the facility on 2/2/22 with diagnoses including seizures and hemorrhagic stroke (bleeding in the brain). Review of the most recent admission Minimum Data Set (MDS) Assessment dated 2/5/22 identified Resident #33 as moderately cognitively impaired with no rejection of care behaviors. He had highly impaired hearing with no hearing aid and impaired vision with corrective lenses. Review of the Care Plan, revision date 2/17/22, documented a Focus area for Resident #33 had impaired visual function and needed glasses to read/use communication board. Interventions in meeting the goal of Resident #33 to use appropriate visual devices (glasses/communication board) to promote participation in activities of daily living (ADL) and	F 656	F-656 1. The facility implemented the communication deficit care plan for resident #33 and initiated a care plan for foley catheters for resident #40 prior to the end of survey. 2. All residents with communication deficits and foley catheters are at risk for deficient practice. On or before 5/10/22 an audit was completed for current facility residents who have communication deficits and foley catheters. Care plans were reviewed and revised by the MDS Coordinator and the Director of Nursing to ensure comprehensive care plans are in place. 3. On or before 5/10/2022 the Regional Clinical Reimbursement Coordinator provided education to the Interdisciplinary Team (DON, ADON, THERAPY, ACTIVITIES, DIETARY, SDC, UC, SW, and administrator on completion of comprehensive care plans for residents with foley catheters and implementing/following care plans for residents with communication deficits. On	

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F 656	Continued From page 25 other activities included ensure appropriate visual aids (glasses and communication board) were available to support resident's participation in activities. Observations of Resident #33 on 3/28/22 at 8:20 AM revealed Nurse Aide (NA) #6 did not use white board or provide glasses when breakfast was delivered/served. Resident #33 was able to feed himself finger foods, such as bread, but he was shaky and unable to use the utensils on his own. Observations of Resident #33 on 3/29/22 at 8:33 AM revealed Nurse #3 and NA #6 did not use white board or provide glasses when breakfast was delivered/served. Resident #33 yelled out, "I can't hear you, why don't you leave me alone?!" NA #6 placed a piece of bread and sausage in his hand, and he yelled: " You know I don't understand you!" During an interview on 3/28/22 at 8:20 AM with NA #6, who worked with Resident #33 twice, she stated she received report from Nurse #4 to communicate with him by talking loudly in his ear. During a follow-up interview with NA #6 at 8:38 AM, she stated Resident #33 did not wear glasses. Nurse #3 was interviewed on 3/29/22 at 8:45 AM. She stated she did not know to use the white board/glasses for communicating with Resident #33. Nurse #3 further stated the facility used to have a binder for resident activities of daily living (ADL) care, but now everything is done on the computer. This surveyor had to shower Nurse #3 how to access the care plan.	F 656	or before 5/10/22 the Director of Nursing and Unit Coordinators educated all facility and agency licensed nurses and nurse aides on implementing the comprehensive care plan related to communication deficits. All newly hired facility and agency licensed nurses will receive education prior to working as part of the orientation process. 4. The Director of Nursing and/or Unit Coordinators will conduct random audit to verify interventions are implemented for residents with communication deficits and care plans are initiated for residents with foley catheters. Monitoring will be conducted with (5) residents 1 x week for (12) weeks. and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance. 5. Completion Date: 5/10/2022	

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F 656	Continued From page 26	F 656		

During an interview with Nurse #4 on 3/29/22 at 9:30 AM, she stated she had worked with Resident #33 for the last few weeks and communicated with him by talking very loudly. Nurse #4 indicated Resident #33 did not wear glasses and never saw glasses in his room. She stated she retrieved details on Resident #33's care from the other staff who worked with him previously but had not looked at his care plan.

Multiple attempts were made with Resident #33 for an interview, but he refused to communicate even when whiteboard and glasses were used.

During an interview with the Regional Director of Clinical Service (RDCS) on 3/30/22 at 12:44 PM with the Administrator and Director of Nursing present, she stated her expectation was that staff should follow the care plan as developed and use the proper communication devices with Resident #33 at all times.

2. Resident #40 was admitted to the facility on 2/11/22 with diagnosis of fracture of Thoracic Spine, Vertebrae 9 and 10 with spinal cord injury.

The Admission Minimum Data Set (MDS) Assessment dated 2/17/22 revealed the resident was cognitively intact and had an indwelling urinary catheter.

There was no care plan for Resident #40's urinary catheter.

On 3/27/22 at 4:10 PM Resident #40 was observed to be lying in bed on an air mattress and the resident had an indwelling urinary catheter.

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F 656	Continued From page 27 On 3/29/22 at 4:56 PM an interview was conducted with MDS Coordinator and the Corporate MDS Nurse. The MDS Coordinator stated she normally did a care plan for a urinary catheter but did not do one for Resident #40. The Corporate MDS Nurse confirmed the urinary catheter should have been care planned. On 3/30/22 at 1:20 PM an interview was conducted with the Regional Director of Clinical Services stated that the care plan should be appropriate to the resident's condition.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide safe care for a resident that required extensive assistance and was on an air mattress for 1 of 2 residents reviewed for accidents (Resident # 40). The findings included: Resident #40 was admitted to the facility on 2/11/22 and had a diagnosis of paraplegia (paralysis of the lower body).	F 689	F- 689 1. Resident #40 will continue to be provided with 2-person staff assistance with bed mobility and a specialty mattress to ensure safety during care. Care plan, Kardex/task profile updated accordingly. 2. The Director of Nursing and/or Unit Coordinators reviewed all residents with specialty mattresses and/or those who require extensive to total assistance with	5/10/22

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F 689	Continued From page 28 The Admission Minimum Data Set (MDS) Assessment dated 2/17/22 revealed the resident was cognitively intact, was not ambulatory and required extensive assistance for bed mobility and toileting, total assistance for bathing and had impairment in range of motion of the lower extremities on both sides. The MDS revealed the resident had an indwelling urinary catheter and was incontinent of bowel. The MDS noted the resident had a fracture related to a fall in the 6 months prior to admission and had recent surgery requiring active skilled nursing facility care. The resident's current care plan dated 2/25/22 revealed the resident had a self-care deficit due to impaired physical mobility related to recent spinal surgery. The care plan noted the resident required extensive assistance by staff to turn and reposition in bed. Review of a nurse's note dated 3/14/22 at 7:45 PM signed by Nurse #2 revealed Resident #40 fell from the bed while the Nursing Assistant (NA) was in the process of cleaning up the resident. The NA said she was turning him towards the door and his legs slid off the bed and he fell off. He was bleeding from his nose which has stopped with pressure. The indwelling urinary catheter pulled out as well and there were several scratches on his upper back. The Physician and the family were made aware. Review of the incident report dated 3/14/22 revealed the resident fell from his bed while the NA was in the process of cleaning him up. The NA stated she was turning him towards the door and his legs slid off the bed and he fell off. He was bleeding from his nose which had stopped	F 689	bed mobility to ensure care plan and Kardex/task profile updated to indicate 2-person staff assistance with bed mobility for safety. Audit and care plan/Kardex/Task profile updates completed on or before 5/10/22. 3. On or before 5/10/22 the Staff Development Coordinator (SDC) reeducated current facility and agency licensed nurses and nurse aides regarding safety during bed mobility for residents requiring extensive to moderate assistance with 2-person staff assistance and following the plan of care indicated on the care plan/Kardex/task profile of the medical record. All newly hired facility and agency licensed nurse and nurse aides will be educated regarding safe resident handling with 2-person assistance for bed mobility prior to working as part of the orientation process. 4. The Staff Development Coordinator or Unit Coordinator will conduct random audits via observation regarding safe handling of the residents according to the Care Plan/Kardex/Task profile. Audits will be conducted three (3) times weekly for eight (8) weeks then weekly for four (4) weeks. These audits will include no less than 10% of the daily census of the facility. All data will be summarized and presented to the facility QAPI meeting monthly by the Staff Development Coordinator. Any issues or trends identified will be addressed by the QAPI	

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F 689	Continued From page 29 with pressure. The indwelling urinary catheter was pulled out as well and there were several scratches on his upper back. The Resident's description of the incident revealed "My legs were sliding, and I fall off the bed and hit my nose on the corner of the drawer." The immediate action included the resident was assessed for injuries, vital signs taken and transferred the resident back to the bed with a mechanical lift. Bed in the lowest position and the call bell placed in reach. The air mattress was operating normally. There were no additional interventions listed on the incident report. On 3/27/22 at 4:20 PM the Resident stated in an interview that he had one fall since admitted to the facility. The Resident stated a NA came in to change him (provide incontinence care) by herself and then she turned him over, he had spasms in his legs and his legs fell over the side of the bed and he rolled off the bed onto the floor. On 3/28/22 at 4:34 PM an interview was conducted with Nurse #2 who was the 3 PM to 11 PM shift supervisor. Nurse #2 stated she was coming down the hall and heard a big boom and NA #3 called out to her. Nurse #2 stated she went in the room and Resident #40 was face down on the floor and the indwelling urinary catheter was out and there was blood on the floor where his nose had bled. The Nurse further stated at the time the NA changed the resident by herself, but the Resident had requested to be changed with two persons after the fall. The Nurse stated she called the Physician and discussed the incident with him and decided the resident did not need to go to the hospital. On 3/28/22 at 4:40 PM an interview was	F 689	committee as they arise, and the plan will be revised to ensure continued compliance. 5. Completion Date: May 10, 2022	

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F 689	Continued From page 30	F 689		

conducted with NA #3 who was working with Resident #40 when he fell off the bed. The NA stated she was changing Resident #40 and she rolled him over and he fell off the bed. The NA stated she turned him away from her and was cleaning him up and looked up and he was going over the side of the bed and hit the floor face down. The NA stated she called the nurse, and the nurse came in and did an assessment and they got the mechanical lift and transferred him back to the bed. The NA stated there was blood on the floor, but she did not know where it came from. The NA stated the only information regarding patient care she gets is from the nurse. The NA stated she had changed him before by herself but did not know what happened to cause him to fall off the bed and had not worked with the resident since that time.

The care plan for Resident #40 was updated on 3/29/22 and read: "Staff education related to 2 person assistance when turning and repositioning when on a specialty mattress."

On 3/30/22 at 10:36 AM an interview was conducted with the Regional Director of Clinical Services. The Director stated the NAs were supposed to look under the task tab in the computer to see how many persons were required to care for the resident. The Director was observed to pull up the resident's care under the task tab and stated it had not been updated. The Director further stated the Kardex (NA care guide) says extensive assistance with bed mobility and the NAs know that this means 2 persons are required to provide care for the resident. The Director stated Resident #40 was provided incontinent care with one person assist when he fell off the bed and they did an

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F 689	Continued From page 31 investigation to determine the root cause and he was on a specialty mattress (air mattress) and should have had 2 persons assisting with the care. The Director further stated they did an in-service for the staff related to the fall and that 2 persons should provide care for the resident.	F 689		
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6) §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related	F 729		5/10/22

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F 729	Continued From page 32 services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review, review of Nurse Aide Registry forms and staff interviews the facility failed to verify with the North Carolina Nurse Aide Registry a Nursing Assistant's (NA) certification for 2 of 5 employees reviewed (NA #1 and NA #2). The findings included: 1. NA #2 was hired by the facility on 1/18/22 and started working on the resident care unit on the same day. The Nurse Aide Registry verification form revealed the facility requested a verification of the NA's certification on 3/1/22 and the NA's certification was current. On 3/30/22 at 5:00 PM an interview was conducted with the Regional Director of Clinical Services who stated the Business Office Manager (BMO) was responsible for processing new employees and NA #4 assisted the BMO with this task. On 3/30/22 at 5:05 PM NA #4 stated in an interview that her process for new employees was to check for the NA's certification upon receiving the employee's application. The NA stated they had to re-run some of them and there might be another one in the file. The Regional Director of Clinical Services was present during the interview and stated she would check the file. On 3/30/22 at 5:20 PM the Business Office Manager stated she could not remember why the	F 729	F 729 1. The facility business office manager verified NA #1 on 2/18/22 and NA #2 on 3/1/22 with the NC Nurse Aide Registry. 2. On or before 5/10/2022 the Administrator or Director of Nursing conducted a 100% audit of all current CNA to assure certification verification results documents are placed inside of the employee records. Any CNA□s files found incomplete were corrected to ensure the facility was not employing someone who has not met the regulation 3. On or before 5/10/2022, re-educating occurred with all members of the onboarding team (Business Office Manager, Assistant Business Office Manager and NA #4) regarding the importance of sequence of the process, maintaining original documents in new hire□s file and providing only duplicates to others in the sequence to avoid loss of originals. Newly hired onboarding team member will receive education as part of the orientation process. 4. The administrator or designee will audit files of new hires for accuracy and	

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F 729	Continued From page 33 verification of the NA's certification was not done prior to the employee working on the resident care unit. On 3/30/22 at 5:35 PM the Regional Director of Clinical Services stated in an interview that the date on the Nurse Aide Registry Verification form was correct. The Director stated she expected the verification of certification to be done prior to the employee working in the facility. 2. Nursing Assistant (NA) #1 was hired by the facility on 2/7/22 and started working independently in the facility on 2/14/22. The Nurse Aide Registry verification form revealed the facility requested verification of the NA's certification on 2/18/22 and the NA's certification was current. On 3/30/22 at 5:00 PM an interview was conducted with the Regional Director of Clinical Services who stated the Business Office Manager (BMO) was responsible for processing new employees and NA #4 assisted the BMO with this task. On 3/30/22 at 5:05 PM NA #4 stated in an interview that her process for new employees was to check for the NA's certification upon receiving the employee's application. The NA stated they had to re-run some of them and this might be the reason the form showed a late date and there might be another one in the file. The Regional Director of Clinical Services was present during the interview and stated she would check the file. On 3/30/22 at 5:20 PM the Business Office	F 729	adherence to the onboarding sequence, weekly for four weeks, and monthly for two more months; then report to the QAPI Committee. Changes will be made to the plan as necessary to maintain compliance. 5. Completion Date: May 10, 2022	

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	345184	A. BUILDING _____ B. WING _____	C 03/30/2022

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F 729	Continued From page 34 Manager stated she could not remember why the verification of the NA's certification was not done prior to the employee working on the resident care unit. On 3/30/22 at 5:35 PM the Regional Director of Clinical Services stated in an interview that the date on the Nurse Aide Registry Verification form was correct. The Director stated she expected the verification of certification to be done prior to the employee working in the facility.	F 729		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). 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	F 755		5/10/22

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F 755	Continued From page 35 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to acquire prescribed medication for administration resulting in failure to administer 2 medications as ordered by the physician for 1 of 7 residents (Resident #58) whose medications were reviewed. Findings included: Resident #58 was admitted to the facility on 12/31/21 and discharged on 1/1/22 with diagnoses that included left thigh bone fracture, scoliosis, and stroke. A Minimum Data Set (MDS) assessment was not available at the time of the investigation. A physician order dated 12/31/21 for Methocarbamol (muscle relaxant) 500 milligrams (mg) by mouth 4 times daily for muscle spasms. Another order dated 12/31/21 for Xanax (anti-anxiety) 0.5mg 1 tablet by mouth in the morning for anxiety. On 12/31/21, the physician also ordered Xanax 0.5mg 2 tablets by mouth at bedtime for anxiety. The December 2021 Medication Administration Record (MAR) for Resident #58 revealed the following medications were not administered as ordered on the following dates: - Xanax: 12/31/21 at 9:00 PM	F 755	F755 1. Resident #58 was admitted to the facility on 12/31/21 and discharged Against Medical Advice (AMA) 1/1/22. Corrective action is not applicable due to discharge status. 2. All residents in the facility have the potential to be affected; therefore, an initial facility wide audit of all current resident medication orders was completed to verify medication availability in the medication cart as ordered. Audit was conducted by the facility Unit Coordinators and Director of Nursing on or before 5/10/22, and medications are available for administration as ordered. 3. On or before 5/10/22, the Director of Nursing and Unit Coordinators educated all facility and agency licensed nursing staff on the facility policy and procedure relative to medication availability, ordering, reordering, and receiving to ensure medication administration as prescribed by the physician to prevent medication errors. Education included process of receiving nurse signing pharmacy delivery tickets, placing copy in Unit Manager mailbox, placing medication on	

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F 755	Continued From page 36 - Methocarbamol: 12/31/21 at 12:00 PM - Methocarbamol: 12/31/21 at 5:00 PM - Methocarbamol: 12/31/21 at 9:00 PM The January 2022 MAR for Resident #58 revealed the following medications were not administered as ordered on the following dates: - Xanax: 1/1/22 at 9:00 AM - Methocarbamol: 1/1/22 at 9:00 AM - Methocarbamol: 1/1/22 at 12:00 PM Nursing progress and eMAR notes from 12/31/21 through 1/1/22 were reviewed for Resident #58 and revealed on 12/31/21 eMAR notes at 6:31 PM and 9:31 PM written by the previous Director of Nursing (DON) noted the Methocarbamol medication was not in the building. An eMar note written by Nurse #1 on 1/1/22 revealed Resident #58's medications were not available. A nursing progress note by Nurse #1 on 1/1/22 revealed she contacted the pharmacy to check on the status of the missing medications, and the pharmacy told her they were to be delivered that afternoon. Multiple attempts to contact Resident #58 were made during the investigation, but she was not able to be reached. An interview was conducted on 3/30/22 at 9:55 AM with Nurse #2, who was the day shift nurse for Resident #58 on 12/31/21. She stated she could not recall Resident #58 or the missing medications. During a phone interview on 3/30/22 at 9:01 AM	F 755	medication cart and confirming receipt in the Electronic Medication Record (EMR). The Unit Manager will review delivery tickets and Pharmacy alerts on the EMR order dashboard and follow-up as needed to ensure medication delivery and availability. Newly hired facility and agency licensed nurses will receive education prior to working as a part of the orientation process. 4. The Director of Nursing or Unit Manager will conduct random audits of 5resident medication orders for availability and administration as ordered. Monitoring will be completed five (5) times weekly for3 months and as necessary thereafter. The Director of Nursing will report these finding to the IDT during QAPI meetings monthly and will make changes to the plan as necessary to maintain compliance. 5. Completion Date: May 10, 2022	

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F 755	Continued From page 37	F 755		

with the previous DON, who was the nurse on duty for Resident #58 from 7:00 PM - 7:00 AM on 12/31/21, she revealed certain medications (Methocarbamol and Xanax) were not available during her shift because they were waiting for the pharmacy delivery.

During a follow-up interview with the previous DON on 3/30/22 at 4:48 PM, she revealed she attempted to contact the physician on 12/31/21 at 10:28 PM; however, she did not leave a voicemail. She stated he did not call her back. The previous DON stated the protocol for when medications were not available would be to contact the pharmacy, but they were closed for the holiday, and then contact the physician. If he was reached, he would have submitted the necessary prescriptions immediately.

During another follow-up interview with the previous DON on 3/30/22 at 5:03 PM, she stated she recalled trying a second contact phone number for the pharmacy on 12/31/21 after she attempted to call the physician around 10:00 PM. She finally got in touch with someone and was told the medications was on the way. The previous DON stated she told Resident #58 she would receive her missing medications in the morning. She indicated she forgot to document this information and could not recall if she reported this to the oncoming nurse (Nurse #1).

During an interview on 3/30/22 at 2:00 PM with Nurse #1, who was the nurse on duty from 7:00 AM - 7:00 PM on 1/1/22, she revealed she was not sure if the missing medications were available in the emergency supply located in the facility. Nurse #1 stated she could not recall the details of the medication administrations but did remember

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F 755	Continued From page 38 medications were delivered as Resident #58 left the facility. If a medication was not available, she would call the pharmacy and ask the status of the medication. The Pharmacist in-charge (PIC) was interviewed on 3/30/22 at 10:39 AM. She revealed the pharmacy had received new orders for Resident #58 for Xanax and Methocarbamol on 12/31/21. The PIC stated the medications were delivered to the facility on 1/1/22 at 4:30 PM. She indicated there were no records any nursing staff from the facility contacted the pharmacy for physician authorization to subscribe alternative medications. The Regional Director of Clinical Services (RDCS) was interviewed on 3/30/22 at 1:08 PM with the Administrator and Director of Nursing (DON) present. She revealed her expectation for missing medications was for the physician to be notified to adjust the prescription to the medications available in emergency supply.	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		5/10/22

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F 842	Continued From page 39	F 842		

professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 40 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to maintain accurate records of medication administration for 1 (Resident #58) of 23 residents' medical records reviewed. Findings included: Resident #58 was admitted to the facility on 12/31/21 and discharged on 1/1/22. A physician order dated 12/31/21 for Methocarbamol (muscle relaxant) 500 milligrams (mg) by mouth 4 times daily for muscle spasms. Another order dated 12/31/21 for Xanax (anti-anxiety) 0.5mg 1 tablet by mouth in the morning for anxiety. Review of electronic Medication Administration Record (MAR) notes on 1/1/22 revealed Nurse #1 documented at 11:48 AM Resident #58's medications were not available. Record review of the MAR for the month of January 2022 revealed Methocarbamol was	F 842	F-842 1. Resident #58 was admitted to the facility on 12/31/21 and discharged Against Medical Advice (AMA) 1/1/22. 2. All residents in the facility have the potential to be affected; therefore, an initial facility wide audit of all current resident medication orders was audited to ensure availability in the medication cart. Audit was conducted by the facility Unit Coordinators. The MARs were reviewed for newly admitted residents to ensure accurate documentation of administration. No additional concerns identified. Audit completed on or before 5/10/22. 3. On or before 5/10/22. the Unit Coordinators and Staff Development Coordinator educated all current facility and agency licensed nursing staff on the accurate documentation of medication administration and documentation when	

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F 842	Continued From page 41 coded as not administered on 1/1/22 at 9:00 AM and 12:00 PM by Nurse #1 who documented as resident refused. Nurse #1 also coded the resident refused the Xanax medication that was scheduled for 9:00 AM on 1/1/22. During a phone interview on 3/30/22 at 2:00 PM with Nurse #1, she revealed if a medication was not available, she would code the administration in the MAR as "other/see nurses notes" and document in progress notes. Nurse #1 stated the reason the medications were not administered correctly for Resident #58 was by accident. The Regional Director of Clinical Services (RDCS) was interviewed on 3/30/22 at 2:22 PM with the Administrator and Director of Nursing (DON) present. She revealed nursing staff are expected to use the "other/see nursing notes" code when a medication was not available. She stated education for nursing staff of documentation will be required.	F 842	not available for administration. Education included process of receiving nurse signing pharmacy delivery tickets, placing copy in Unit Manager mailbox, placing medication on medication cart, and confirming receipt in the Electronic Medication Record (EMR). Education on notification to the attending physician if medication not available or administered as ordered for follow-up as indicated. Education for documenting on the MAR when medication is not administered as ordered was also provided. The Unit Coordinator will review delivery tickets and Pharmacy alerts on the EMR order dashboard and follow-up as needed to ensure medication delivery and availability. The DON will review the Electronic Medication Administration Record (EMAR) during morning clinical meeting to ensure compliance with documentation of administration or non-administration of medications as ordered for previous 24-hours and provide follow-up as necessary to ensure accurate documentation in resident records. Newly hired facility and agency licensed nurses will receive education prior to working as a part of the orientation process. 4. The Director of Nursing or Unit Coordinator will conduct random audits of 5 residents medication orders for availability and proper documentation of administration or non-administration per the EMAR and as ordered. Monitoring will be completed 3 times weekly for 4 weeks, then weekly for 8 weeks and as necessary thereafter. The Director of Nursing will	

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F 842	Continued From page 42	F 842	report these finding to the Quality Assurance Process Improvement (QAPI)committee monthly and will make changes to the plan as necessary to maintain compliance with accurate resident medical records. 5. Completion Date: May 10, 2022	