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PELICAN HEALTH HENDERSON LLC	**280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536**

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 9/22/2022 through 9/24/2022. Five of the twenty-six allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC00193177, NC00192952, NC00192739, NC00192454, NC00192322, NC00192207	F 000		
F 559 SS=E	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to provide written notice to 2 (Residents #3 and #11) of 2 residents reviewed for a room change/roommate change. Resident #11 was not given written notification or an opportunity to view the room prior to a room change. Resident #3 was not given written notification prior to receiving a new roommate. Findings included:	F 559		

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

Electronically Signed

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

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1. Resident #11 was admitted to the facility on 5/21/2021 for short term rehabilitation services after a fall. Resident #11 was moved from a private room to a semiprivate room on 8/30/2022.

Documentation on a quarterly minimum data set assessment dated 8/12/2022 coded Resident #11 as cognitively intact with no mood or behavior problems.

Resident #11 was interviewed on 9/22/2022 at 11:44 AM. Resident #11 revealed a previous Administrator had given her permission to have her recliner from her previous home in the community brought to the facility for her use. Resident #11 stated that within two days of the new Administrator arriving she was moved to a smaller room and was not allowed to bring her recliner to her new room with her.

Resident #11 was reinterviewed on 9/22/2022 at 9:04 AM and elaborated on her move to her new room in the facility. Resident #11 stated she woke one morning to find the housekeeper in her room telling her she was moving to a new room that day and going to a double room. Resident #11 stated then the maintenance man was in her room measuring her bed in preparation for the move. Resident #11 further stated the new Administrator came to her room soon after explaining she would be moving to another room that day. Resident #11 confirmed she received no written notice prior to that day, nor did she realize she would not be able to bring her recliner with her.

An interview was conducted with the Administrator on 9/23/2022 at 8:20 AM. The Administrator explained she had been the

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Administrator for three weeks and when she arrived, she realized the facility was without a Social Worker and an Activities Director. The Administrator indicated she was in the role of Administrator, Social Worker, and Activities Director.

An interview was conducted with the facility Administrator on 9/24/2022 at 12:06 PM. The facility Administrator stated Resident #11 was moved from the short-term rehabilitation unit to the long-term care unit in the building. The Administrator acknowledged Resident #11 did not receive written notification of the move or a chance to see the new room prior to moving but received verbal notification and explanation on the day of the move.

2. Resident #3 was originally admitted to the facility on 7/31/2020.

Documentation on a quarterly Minimum Data Set assessment dated 7/4/2022 coded Resident #3 as being cognitively intact.

There was no documentation in the electronic medical record for Resident #3 indicating a discussion or notification of a new roommate in September 2022.

Documentation on the daily census sheet for 9/21/2022 revealed the facility had a census of 51 residents with 26 available beds.

An interview was conducted with Resident #3 on 9/24/2022 at 11:14 AM. Resident #3 stated two weeks ago Resident #15 was moved into his room without any notice and for an unknown reason. Resident #3 confirmed he was not given

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any written notification from the facility he was going to get a new roommate. Resident #3 revealed Resident #15 was his roommate on a previous occasion and he had asked for a room change at that time due to his intolerance of a behavior issue of Resident #15. Resident #3 indicated he was not given a choice or an opportunity to explain or decline Resident #15 as his roommate. Resident #3 did not understand why Resident #15 was moved back in with him. Resident #3 stated in addition he liked to keep his door always closed due to privacy, noises in the hallway and the sensitivity of his hearing aids. Resident #3 stated he was told he could no longer keep his door always closed because he now had a roommate who had the right to have the door open. Resident #15 indicated the door was now always open and it was keeping him awake and waking him up with the continuous noise in the hallway.

An interview was conducted with Nurse Aide (NA #3) on 9/24/2022 at 2:27 PM. NA #3 explained she routinely cares for Resident #3 on the 7:00 AM to 3:00 PM shift and was aware of his care needs and preferences. NA #3 stated Resident #3 has always kept his door closed in the past but since Resident #15 was moved into his room the door was always kept open. NA #3 stated Resident #3 liked to stay in his room in his bed and indicated he did not need close monitoring as he was able to voice his needs. NA #3 stated Resident #3 had not been asking her to close the door, but she knew he liked the door closed. NA #3 went on to explain the door had to be kept open because Resident #15 required frequent monitoring for falls and safety issues due to his diagnoses and behaviors. NA #3 indicated the frequent monitoring and assistance required for

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Resident #15 was best accomplished by viewing him from the hallway as nurse aides passed in the hallway. NA #3 did not know why Resident #15 was moved into the room of Resident #3.

An interview was conducted with the Administrator on 9/23/2022 at 8:20 AM. The Administrator explained she had been the Administrator for three weeks and when she arrived, she realized the facility was without a Social worker and an Activities director. The Administrator indicated she was in the role of Administrator, Social Worker, and Activities Director.

Follow-up interviews were conducted with the Administrator on 9/24/2022 at 11:00 AM and 2:49 PM. The Administrator stated she did not realize Resident #3 and Resident #15 were previously roommates. The Administrator revealed she did not know why Resident #15 was moved into the room with Resident #3 and she acknowledged Resident #3 did not receive written notification he was getting a new roommate. The Administrator indicated she did not know if any notice or discussion about compatibility of roommates was held with Resident #3 prior to Resident #15 moving into the room. The Administrator indicated she did not know who was responsible for the move of Resident #15. The Administrator revealed she was unaware written notice was required but she would look for the facility policy and procedures for room changes. The Administrator indicated she was the one who was notifying and discussing room changes with the residents. The Administrator stated Resident #3 was not told the door to his room had to stay open continuously, but the roommate, Resident #15, had a right to have the door open. The

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F 559	Continued From page 5 Administrator stated if Resident #3 had an issue with his roommate, he was the one who had to move. The Administrator stated she was unaware Resident #3 and Resident #15 were previous roommates and Resident #3 was going to be moved to another room.	F 559		
F 560 SS=D	Right to Refuse Certain Transfers CFR(s): 483.10(e)(7)(i)-(iii)(8) §483.10(e)(7) The right to refuse to transfer to another room in the facility, if the purpose of the transfer is: (i) to relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or (ii) to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF. (iii) solely for the convenience of staff. §483.10(e)(8) A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to offer an opportunity for refusal for a room change for 1 (Resident #11) of 1 resident reviewed for transfer to a new room in the facility. Findings included: Resident #11 was admitted to the facility on 5/21/2021 for short term rehabilitation services after a fall. Resident #11 was moved from a private room to a semiprivate room on 8/30/2022.	F 560		

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Documentation on a quarterly minimum data set assessment dated 8/12/2022 coded Resident #11 as cognitively intact with no mood or behavior problems.

Resident #11 was interviewed on 9/22/2022 at 11:44 AM. Resident #11 revealed a previous Administrator had given her permission to have her recliner from her previous home in the community brought to the facility for her use. Resident #11 stated that within two days of the new Administrator arriving she was moved to a smaller room and was not allowed to bring her recliner to her new room with her.

Resident #11 was re-interviewed on 9/22/2022 at 9:04 AM and elaborated on her move to her new room in the facility. Resident #11 acknowledged she had a discussion with the Administrator on the day of her move to her new room. She said the Administrator explained to her she was in a private room and the room was needed to be available for a resident who was paying for the extra cost of a private room. Resident #11 stated the Administrator discussed with her that she would be moved to the double occupancy room unless she was able to obtain the extra money for the cost of a private room. Resident #11 stated she wanted the private room because she wanted to keep the recliner in her room. Resident #11 explained she had a goal to get back to walking again and she made a deal with the physical therapist that she could return to therapy services if she was willing to show the willingness to sit up in her chair for 4 hours each day. Resident #11 stated she could easily stay up in her recliner for 4 hours and she enjoyed doing so to watch television in the evening. Resident #11 revealed when she was sitting up in her recliner for just a

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moment, she felt like she was at home, and she had the recliner for as long as she had been at the facility. Resident #11 stated she saw her recliner was put in an office in the front of the building and she was unsure what was going to happen to it. Resident #11 stated she was not given an opportunity to refuse the transfer to a new room unless she was able to come up with the 100 dollars a month more that was required for the room.

Interviews were conducted with the Administrator on 9/23/2022 at 8:20 AM and 11:00 AM. The Administrator explained she had been the Administrator for three weeks and when she arrived, she realized the facility was without a social worker and an activities director. The Administrator indicated she was in the role of Administrator, Social Worker, and Activities Director. The Administrator stated she personally explained everything to Resident #11, and she was spoken to at length prior to her move to a new room in the facility. The Administrator confirmed the recliner was discussed with Resident #11. The Administrator revealed Resident #11 wanted to know where the recliner was going to fit in the room, and she was told the recliner may not fit in the new room.

An additional interview was conducted with the Administrator on 9/24/2022 at 12:06 PM. The Administrator confirmed all the beds in the facility were certified for Medicare and Medicaid payments. The Administrator explained the purpose of changing rooms for Resident #11 was not for staff convenience, but to move her from the rehabilitation section of the nursing home to the long-term care section of the nursing home. The Administrator acknowledged Resident #11

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F 560	Continued From page 8 was not allowed to see the new room she was moving to so she could visualize that the recliner was not going to fit.	F 560		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §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;	F 584		

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§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 interview the facility failed to provide blinds or window coverings in good repair for 4 of 6 hallways reviewed for a clean, comfortable, and homelike environment. The rooms included 109, 125, 127, 130, 132, 136, 137, 139, 140, 144, 145, 148 and a hall bathroom between rooms 123 and 125.

Findings included:
1. Observations were made on 9/22/2022 beginning at 10:25 AM on an initial tour of the facility revealing Rooms 139, 148 and 144 had broken or missing slats on the blinds.

a. Room 139 was observed on 9/22/2022 at 10:25 AM. The blinds in the window in room 139 had bent and broken slats such that a view into the room from a staff smoking area was visible through the blinds.

b. Room 148 was observed on 9/22/2022 at 11:07 AM. The blinds in window in the room had the bottom half missing and broken revealing a view inside the room from a courtyard area.

c. Room 144 was observed on 9/22/2022 at 11:12 AM. The window blinds in the room 144 had bent slats on the right side and two broken slats on the left side.

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An interview was conducted with the director of maintenance on 9/22/2022 at 11:16 AM. The Director of Maintenance was notified of the observations of broken blinds in rooms 139 and 148 in the facility as examples of blinds in disrepair. The Director of Maintenance stated he had noted and had previously made a list of approximately 60 blinds in the facility that needed to be replaced. The Director of Maintenance explained the purchasing and replacement of the blinds was in the process of approval, but he could not explain where the blinds were in the approval process or who's approval was needed.

An additional interview was conducted with the director of maintenance on 9/22/2022 at 2:55 PM. The Director of Maintenance stated he went and purchased blinds and replaced the blinds in room 139 and 148.

2. An observation was made of Room 140 on 9/22/2022 at 2:57 PM. The blinds in the window had several bent and broken slats.

3. Additional observations of window blinds were made on 9/24/2022 beginning at 8:00 AM of rooms 109, 125, 130, 136, 145, 137, 132, 127, 109, and a hallway bathroom between rooms 123 and 125.

a. An observation was made on 9/24/2022 at 8:00 AM of the window blinds in Room 109. The window blinds were broken and bent in the middle on the right side creating a hole creating a hole through which the air conditioning unit was visible.

b. An observation was made on 9/24/2022 at 8:01 AM of the hallway bathroom located across from

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the central nursing supply room and in between Rooms 123 and 125. The hallway bathroom had no blind or window covering for the window.

c. An observation was made on 9/24/2022 at 8:03 AM of Room 125. The window blinds in Room 125 had broken and missing slats on both the left and right side of the window.

d. An observation was made on 9/24/2022 at 8:04 AM of Room 130. The window blinds had broken and missing slats on both the left and right sides of the window.

e. An observation was made on 9/24/2022 at 8:05 AM of Room 136. The window blinds had two and a half slats that were missing on the right side of the window.

f. An observation was made on 9/24/2022 at 8:06 AM of Room 145. The window blinds had a bent slat on the left side of the blind and missing slats in six sections of the blind on the right side.

g. An observation was made on 9/24/2022 at 8:14 AM of Room 137. The window blinds had bent and broken slats creating an opening at the bottom of the blind.

h. An observation was made on 9/24/2022 at 8:21 AM of Room 132. The window blind was missing a six-by-six square on the right side.

i. An observation was made on 9/24/2022 at 8:27 AM of Room 127. The window blind had two slats missing at the bottom.

An interview was conducted with the facility Administrator on 9/23/2022 at 4:10 PM. The

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F 584	Continued From page 12 Administrator stated that she instructed the director of maintenance to go out and purchase blinds for the rooms and he would do so as soon as he was back from vacation. The Administrator explained she had identified the blinds as in need of repair or replacement, but she had not yet had a chance to address the concern	F 584		
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)-	F 656		

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F 656	Continued From page 13 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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, staff interview, and family interview the facility failed to develop a comprehensive care plan for discharge planning for one (Resident # 14) of two sampled residents reviewed for discharge planning. The findings included: Resident # 14 was admitted to the facility on 8/11/22. Resident # 14's Minimum Data Set Assessment, dated 8/19/22, coded Resident # 14 as severely cognitively impaired. The resident was also coded as expected to stay in the facility with no discharge plan. As of an initial review of her record on 9/22/22 there were no discharge plans for the resident. On the resident's care plan, which contained no date regarding when it was added, there was a notation, "the resident wishes to remain in the facility for long term care." Resident # 14's Responsible Party (RP), the resident's spouse, was interviewed on 9/22/22 at	F 656		

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2:15 PM and reported the following. The RP lived one and a half hours away from the facility. When Resident # 14 had been initially placed at the facility on 8/11/22 the hospital could not find a nursing home closer who would accept Resident # 14. He worked on a daily basis and would try to still drive daily to see Resident # 14. He really wanted her closer to their home. He suggested speaking to one of his children for additional details related to communication with the facility staff.

Family Member #1 was interviewed by phone on 9/23/22 at 10:25 AM and again on 9/24/22 at 1:00 PM. This family member reported the following. When Resident # 14 was placed at the facility it was with the understanding that it would not be long term and that the family wanted her moved to a facility closer to their home. Since Resident #14 had been admitted he had talked to the Administrator and communicated that this was the goal for the resident and she had given him five to seven names of facilities closer to home, but no more help had been provided to them.

Interview with the MDS (Minimum Data Set) assessment nurse on 9/23/22 at 1:05 PM revealed that she knew the hospital had originally tried to place the resident closer to home in August 2022 but was not able to do so. There had been no social worker to be involved in her care plan discharge goals since Resident # 14 had resided at the facility. She was not aware the resident's family wanted her transferred and therefore she had not added it to the care plan.

The Administrator was interviewed on 9/23/22 at 12:40 PM revealing the following information. The current week was her third week working at the

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F 656	Continued From page 15 facility. The Social Worker had recently left and she was trying to find a replacement. She was trying to do her best in communicating with families and facilitating making sure their needs were met, but she had just started and was currently filling many roles. She had talked to Resident # 14's RP and Family Members #1 and #2 and knew they wanted to get the resident closer to home. She had given them a list of facilities closer to them and was waiting to hear back from the family about future steps they wanted to take. On 9/24/22 the care plan for Resident # 14 was revised to reflect an initiation date of 9/22/22 for a different discharge plan. The plan was, "The resident wishes to be discharged to another facility closer to family for LTC [long term care]."	F 656		
F 660 SS=E	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be	F 660		

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updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent

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the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and family interview the facility failed to implement an effective discharge planning process for two (Residents # 1 and # 14) of two residents who wished to transfer to an alternate facility.
The findings included:

1. Resident # 1 was admitted to the facility on 8/25/22.

Resident # 1's Minimum Data Set assessment, dated 8/29/22, revealed the resident was unable to complete the Brief Interview for Mental Status assessment and had short term memory impairment. The resident was not coded as having a plan in place for discharge.

According to the record, Resident # 1 discharged to an alternate skilled facility on 9/20/22. Review of progress notes revealed no documentation of actions taken to facilitate helping Resident # 1

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F 660	Continued From page 18 move to the alternative facility on 9/20/22. Resident # 1's Responsible Party (RP) was interviewed on 9/22/22 at 4:34 PM and reported the following: She, the resident, and another family member had wanted Resident # 1 to be transferred to another facility soon after she was admitted. Arrangements were made for this. The resident had been accepted by the other facility and everything was in place for transfer for the date of 9/6/22; except for the resident's PASRR (Preadmission Screening and Resident Review; a screening tool to assure residents who might have mental illness, intellectual or developmental disabilities receive appropriate placement and services). There was no social worker or other person at the facility to facilitate getting the PASRR screening and verification number accomplished. She was eventually referred to the Business Office Manager who was to work on trying to get the PASRR. Daily she inquired to the nurses or to the Business Office Manager about the PASRR, but the communication was very poor at the facility. There did not seem to be anyone she could go to for help and at times she would ask for follow up from the nurses or ask that the nurses request the Business Office manager to call her back. She was told the Administrator was always in a meeting when she tried to call and talk to her. She had talked to the DON (Director of Nursing) who told her the facility would get the PASRR done, but the DON later relayed during another conversation that she (the DON) did not have the means herself to get the screening requested and accomplished. After being directed to the Business Office Manager she was told no one at the facility could get into a computer system to obtain the needed PASRR screening and information so the resident could	F 660		

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leave. Sometime between the dates of 9/6/22 and 9/14/22 she was told the Business Office Manager would go on 9/14/22 to another facility, which was owned by the same corporation, and try to request the screening and verification by using their computer system. During this wait time, Resident # 1 had not been pleased with staying at the facility but had no option but to do so because there was no one to help facilitate this last needed part of getting her to the other facility. Although the resident had been accepted and ready to leave on 9/6/22, it took until 9/20/22 before the resident could leave.

The DON was interviewed on 9/24/22 at 11:10 AM and reported she only recalled that Resident # 1's RP had shared with her that she (the RP) was from out of state and was trying to facilitate getting Resident # 1 to another facility. She did not recall anything else about the resident or what had transpired.

The Business Office Manager was interviewed on 9/24/22 at 9:35 AM and reported the following. She confirmed Resident # 1 had been ready to transfer to another facility on 9/6/22 but there had been no one at the facility who could facilitate getting the PASRR completed. By 9/6/22 the facility had helped get a FL2 form (a form used for discharge orders and level of care) completed and signed by the physician and Resident # 1 had been accepted by an alternative facility. The resident only needed a PASRR screening and verification to complete the discharge process. Usually residents were admitted to the facility with the PASRR completed, but prior to 9/1/22 there had been a waiver that allowed residents to be transferred to facilities with the expectation the receiving facility obtain the PASRR screening and

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F 660	Continued From page 20 verification within 30 days. Therefore, Resident # 1, who had been admitted in August 2022, had not had one done prior to her admission to the facility. Since the waiver was no longer in place, Resident # 1 needed one before being transferred to the alternative facility on 9/6/22. The family did want her moved on 9/6/22 and she was aware they were calling daily and inquiring about when the PASRR could get accomplished. There had been no one at the facility that could access the NCMUST (North Carolina Medicaid Uniform Screening Tool-a computer interface system to facilitate the screening and verification process). She (the Business Office Manager) had been certified to access the system in a different county and she had been asked to help with Resident # 1, but she learned that you must access the system within the location the resident currently resides in order to start the process. She had not been approved to do so and no one else in the facility had either. In order to be approved, the facility employee must have a NC Identification number for the county for which they are trying to access the NCMUST system. If an employee had that ID number then they could access the system, and then they could request a screening for a resident and receive verification through the system it was completed. This in turn could be sent to the facility where another resident was transferring. According to the Business Office Manager if a social worker/employee had access to the system then it usually took 24 hours to get a level one PASRR screening and verification completed and 24 to 48 hours for a level two PASRR screening and verification. The Business Office Manager was able obtain the needed ID to access the system but this took time. Once she obtained the access, then the screening took place immediately and	F 660		

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the resident was discharged on 9/20/22. The Business Office Manager verified that helping get Resident # 1 to the alternative nursing home could have gone faster if there had been someone at the facility who could have accessed the system and facilitated getting the screening accomplished.

The Administrator was interviewed on 9/23/22 at 12:40 PM revealing the following information. The current week was her third week working at the facility. The Social Worker had recently left and she was trying to find a replacement. She was trying to do her best in communicating with families and facilitating making sure their needs were met, but she had just started and was currently filling many roles.

2. Resident # 14 was admitted to the facility on 8/11/22.

Resident # 14's Minimum Data Set Assessment, dated 8/19/22, coded Resident # 14 as severely cognitively impaired. The resident was also coded as expected to stay in the facility with no discharge plan.

As of an initial review of her record on 9/22/22 there were no discharge plans for the resident. On the resident's care plan, which contained no date regarding when it was added, there was a notation, "the resident wishes to remain in the facility for long term care."

Resident # 14's Responsible Party (RP), the resident's spouse, was interviewed on 9/22/22 at 2:15 PM and reported the following. The RP lived one and a half hours away from the facility. When Resident # 14 had been initially placed at the

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facility on 8/11/22 the hospital could not find a nursing home closer who would accept Resident # 14. He worked and on a daily basis and would try to still drive daily to see Resident # 14. He really wanted her closer to their home. He suggested speaking to one of his children for additional details related to communication with the facility staff.

The medical record listed Resident # 14's children (Family Members #1 and #2) as contacts.

Family Member #1 was interviewed by phone on 9/23/22 at 10:25 AM and again on 9/24/22 at 1:00 PM. This family member reported the following. When Resident # 14 was placed at the facility it was with the understanding that it would not be long term and that the family wanted her moved to a facility closer to their home. It was his understanding that the hospital Social Worker had communicated this to the facility. Since Resident #14 had been admitted he had talked to the Administrator and communicated that this was the goal for the resident and she had given him five to seven names of facilities closer to home, but no more help had been provided to them. He stated he could have accessed this information on the internet. Both he and Family Member #2 worked full time. His job took him even further away from the direction of the facility where Resident # 14 resided on a daily basis so it was difficult for him to also come to see Resident # 14. He knew there were questions that needed to be asked of facilities such as if they would accept a Medicaid resident with Resident # 14's diagnoses. Resident # 14's RP did not really have the capability to systematically go through and contact facilities and ask them the questions. He

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and Family Member #2 also did not have the time either but were trying to do so when they could. There had never been a care plan meeting with all the family members to provide input to discuss what could be done about getting Resident # 14 closer. He referred to the facility as providing "very little help" to them.

Interview with the MDS (Minimum Data Set) assessment nurse on 9/23/22 at 1:05 PM revealed that she knew the hospital had originally tried to place the resident closer to home in August 2022 but were not able to do so. There had been no social worker to be involved in her care plan discharge goals since Resident # 14 had resided at the facility. Although she did not recall the date, she (the MDS Nurse) had met informally with Resident # 14's RP at the bedside who said he understood Resident # 14 would need long term care and not be able to go home. She was not aware the resident's family wanted her transferred.

The Administrator was interviewed on 9/23/22 at 12:40 PM revealing the following information. The current week was her third week working at the facility. The Social Worker had recently left and she was trying to find a replacement. She was trying to do her best in communicating with families and facilitating making sure their needs were met, but she had just started and was currently filling many roles. She had talked to Resident # 14's RP and Family Members #1 and #2 and knew they wanted to get the resident closer to home. She had given them a list of facilities closer to them and was waiting to hear back from the family about future steps they wanted to take.

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F 660	Continued From page 24 On 9/24/22 the care plan for Resident # 14 was revised to reflect an initiation date of 9/22/22 for a different discharge plan. The plan was, "The resident wishes to be discharged to another facility closer to family for LTC [long term care]."	F 660		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, Responsible Party and staff interview the facility failed to 1) ensure dressing changes were completed for Resident # 12's surgical site as ordered and 2) coordinate care with the hospital and obtain records of diagnostic tests to clarify if treatment was needed for Resident # 1 after she was evaluated at the hospital and sent back for care at the facility. This deficient practice affected 2 of 14 sampled residents. Findings included: 1. Resident # 12 was admitted to the facility on 8/26/22 after undergoing an amputation of his leg. An admission Minimum Data Set assessment, dated 9/2/22, coded the resident as moderately cognitively impaired.	F 684		

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An admission nursing note on 8/26/22 at 10:30 PM revealed the resident had undergone the amputation of his leg on 8/23/22 and still had staples intact to the surgical site when admitted to the facility. The nurse further noted the surgical wound had brownish drainage, and a gauze dressing and ace wrap remained in place to the surgical wound.

On 8/27/22 an order was entered into the electronic record to change the stump dressing daily. The wound was to be cleaned with normal saline and a Xerofoam gauze dressing (a type of gauze containing an antimicrobial compound) applied followed by a gauze wrap.

Review of Resident # 12's August Treatment Administration Record (TAR) revealed there were no orders for the stump dressing entered on the TAR from 8/27/22 through 8/29/22. There was no documentation in the record that the dressing was changed during these dates.

On 8/30/22 an order for the stump dressing was entered into the electronic record to cleanse the wound with wound cleanser and apply Xerofoam. The area was then to be covered with a dry dressing and wrapped with a gauze dressing. This order was initiated on the TAR on 8/30/22.

Review of the record revealed beginning 8/30/22 the dressing to the stump was completed as ordered.

A review of the record did not reveal any problems with the stump incision wound healing.

Resident # 12's stump was observed on 9/23/22 at 10:55 AM to be healed.

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On 9/23/22 at approximately 12:40 PM the Administrator provided a list of nurses who would have been assigned to care for Resident # 12. The Administrator stated the dressing would have been changed by either these day shift or evening shift nurses. These nurses were:
8/27/22 day shift-Nurse # 4
8/27/22 evening shift -Nurse # 5
8/28/22 day shift-Nurse # 6
8/28/22 evening shift-Nurse # 5
8/29/22 day shift-Nurse # 3
8/29/22 evening shift-Nurse # 4

Nurse # 3 was interviewed on 9/23/22 at 2:20 PM and reported she did not do a dressing change to the resident's stump on 8/29/22 and she would not have known to do so since the order did not show up on the TAR.

Nurse # 4 was interviewed on 9/23/22 at 2:35 PM and reported the following. She did not do a dressing change to Resident # 12's stump on 8/27/22 or 8/29/22 and would not have known to do so because it was not on the TAR.

Nurse # 5 was interviewed on 9/23/22 at 4:37 PM and also reported she did not do dressing changes for Resident # 12's stump on 8/27/22 and 8/29/22.

Nurse # 6 was interviewed on 9/24/22 at 6:30 AM and reported if the order was not on the TAR then she would not have known to do the dressing and could not recall anything specifically about the dressing changes.

The Director of Nursing was interviewed on 9/24/22 at 11:10 AM and reported the following.

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She reviewed the medical record and stated that the order was showing up as correctly entered on 8/27/22 in their electronic medical record system. Therefore, it should have generated the order to also show on the August TAR for the dates of 8/27/22 through 8/29/22. She also could not find that the stump dressing order had been on the TAR during the dates of 8/27/22 through 8/29/22, and she did not know why this had occurred.

2. Resident # 1 resided at the facility from 8/25/22 until 9/20/22.

Resident # 1's Minimum Data Set assessment, dated 8/29/22, revealed the resident was unable to complete the Brief Interview for Mental Status assessment and had short term memory impairment.

On 9/15/22 (Thursday) at 4:20 PM a nurse documented in the record that Resident # 1's family member reported Resident # 1's stomach was hurting. The resident was assessed and found to have a blood pressure which registered 73/46, followed by subsequent readings of 66/43 and 105/66. The nurse further documented the physician was contacted and Resident # 1 was transferred to the hospital for evaluation.

On 9/16/22 (Friday) at 10:30 PM a nurse documented Resident # 1 had returned that Friday morning and was without pain.

Review of hospital paperwork, which was sent from the hospital with the resident on 9/16/22 and located in the resident's facility chart, revealed the following. It had been printed on 9/15/22. It was labeled as "After Care Instructions" and written in laymen's terms as directed to Resident # 1. It

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noted, "You have been diagnosed with a basic lower urinary tract infection (UTI). This means it does not involve your kidneys or areas other than your bladder." The paperwork also noted Resident # 1 was diagnosed with a low Magnesium level and altered mental status. The paperwork noted the different diagnostic tests which had been done while the resident was at the hospital. The tests included: a complete blood count, a chemistry lab, an Electrocardiogram, Cardiac labs, a urinalysis, a chest x-ray, and a CT scan of the head. The paperwork noted whether the tests were "normal" or "abnormal" but did not include the complete results. All of the tests were marked "normal" or "no acute" problem except for the urinalysis. It was noted to be "abnormal" but there was no full report of the urinalysis. There was no indication in the paperwork that a urine culture had been obtained. The paperwork noted that Resident # 1 should be started on the antibiotic, Rocephin, 1 gram intramuscularly for the next seven days and that a prescription had been sent to the facility for the Rocephin.

There were no nursing progress notes regarding follow up with the hospital about obtaining further documentation of the diagnostic tests which had been done at the facility or that the resident was being treated for a urinary tract infection.

According to the record Resident # 1 was transferred to another facility on 9/20/22 and she never received an antibiotic for a urinary tract infection.

Resident # 1's RP (Responsible Party) was interviewed on 9/22/22 at 4:34 PM and reported the hospital had said on 9/15/22 the resident had a urinary tract infection and she was concerned

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because the resident never received treatment for it before she was discharged on 9/20/22.

The DON (Director of Nursing) was interviewed on 9/24/22 at 11:10 AM and reported the following. The only paperwork the facility had obtained from the hospital following Resident # 1's 9/15/22 hospital visit were the "After Care Instructions" which were directed towards the resident herself. They currently did not have any of the diagnostic studies done. The DON stated she had called the physician that day (9/24/22) and he had said he had been waiting on the culture results before deciding whether the resident needed the treatment the hospital recommended. The DON stated she would try to get more paperwork from the hospital. The DON stated the hospital typically sent back that a lot of residents had a urinary tract infection but did not send evidence of it to them. She did not think that a culture had ever been done for the resident, but she would investigate and find out if she could determine whether it had. The DON was interviewed regarding what efforts had been made between the dates of Resident # 1's return (Friday; 9/16/22) and her discharge date of 9/20/22 (Tuesday) to obtain more hospital records to help them know if the resident did or did not need treatment. The DON was not sure at the time of the interview but stated she would find out.

During a follow up interview on 9/24/22 at 1:55 PM the DON reported she had talked to the Unit Manager and the Infection Control Nurse and they did not recall efforts made to obtain the hospital documentation of diagnostic studies prior to the resident's discharge. At the time the facility still had not received the diagnostic studies and

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F 684	Continued From page 30 she did not know if the resident had ever had the culture done at the hospital. The DON reported that it would be her expectation that efforts would have been made to obtain the more complete hospital records showing the tests results during the time the resident had resided with them and that this would have been documented in the record. During the date of Resident # 1's record review of 9/24/22, the physician was not available for interview.	F 684		
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.	F 755		

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F 755	Continued From page 31 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to assure for one (Resident # 10) of two residents reviewed for pharmacy services that a medication was acquired from the facility's pharmacy, that facility nurses used their medication administration computer system correctly to reflect accurate administration of the medication, and that the medication was administered correctly. The findings included: Resident # 10 was admitted to the facility on 5/20/22 and had a diagnosis of rhinitis (a reaction in an individual's nose causing symptoms such as nasal congestion, runny nose, sneezing and itching.) Resident # 10's quarterly Minimum Data Set Assessment, dated 8/25/22, coded Resident # 10 as cognitively intact. Resident # 10 had an order, initiated on 2/2/21, for Flonase 10 micrograms one spray to both nostrils two times per day. Resident # 10 was interviewed on 9/22/22 at 10:18 AM and reported he had been without his Flonase for a week and that the nurses could not get it from the pharmacy. He also reported this	F 755		

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F 755	Continued From page 32 led to him having a stuffy nose. Review of Resident # 10's September 2022 Medication Administration Record (MAR) revealed the Flonase was scheduled to be given at 9 AM and 6 PM. The following documentation was on the MAR. 9/19/22 (6:00 PM dose)-Nurse # 5 documented she did not give the medication. 9/20/22 (9:00 AM dose) Nurse # 7 documented a check mark on the MAR indicating it was given. 9/20/22 (6:00 PM dose) Nurse # 3 documented a check mark on the MAR indicating it was given. 9/21/22 (9:00 AM dose) Nurse # 4 documented a check mark on the MAR indicating it was given. 9/21/22 (6:00 PM dose) Nurse # 8 documented a check mark on the MAR indicating it was given. 9/22/22 (9:00 AM dose) Nurse # 7 documented a check mark on the MAR indicating it was given. 9/22/22 (6:00 PM dose) Nurse # 9 documented a check mark on the MAR indicating it was given. 9/23/22 (9:00 AM dose) Nurse # 3 documented the medication was not given. Nurse # 5 was interviewed on 9/23/22 at 4:30 PM and reported the following. She had not given the Flonase on 9/19/22. It was not available and she tried to order it but the computer system showed it had already been ordered. Nurse # 7 was interviewed on 9/23/22 at 2:40 PM and reported the following. She had not administered the Flonase on 9/20/22 or 9/22/22. She was new and still learning the system and was not sure why a check mark appeared on the dates she had given it. She thought she had entered the right information to reflect that it had not been given. She had given the information to another nurse who was helping her with training	F 755		

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F 755	Continued From page 33 to let her know the Flonase needed to be reordered and entered into the system it had been reordered. She thought she had done everything correctly. Nurse # 3 was interviewed on 9/23/22 at 2:20 PM and reported she had not given the Flonase on 9/20/22 or the 9:00 AM dose on 9/23/22. She knew the Flonase had been reordered from the pharmacy and she had called again that current morning. The pharmacy said they would send it in the night shipment of 9/23/22. She thought the Flonase was originally removed from the cart during a pharmacy audit when it was found not to be in a labeled bag. Nurse # 8 and # 9 were interviewed together on 9/24/22 at 10:25 AM and reported the following. They had not administered the Flonase when they had worked. Nurse #9 also thought that the Flonase had at one time been available but had been pulled off the cart during a pharmacy audit. They both thought it was on reorder and Nurse # 8 could not recall for certain but thought she had tried to reorder again. They did not provide a reason why the Flonase was checked off as given. Nurse # 4 was interviewed on 9/24/22 at 1:20 PM and reported she had not given the Flonase on 9/21/22. The nurse did not know why her initials appeared on the MAR because she did not recall that she had even worked that day on that particular medication cart. Interview with the consultant pharmacist on 9/23/22 at 1:40 PM revealed he did not have access at the current time to records and did not recall specifically pulling the Flonase off the cart	F 755		

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F 755	Continued From page 34 during an audit. He did report that if a medication was removed during an audit then nurses are told to reorder it from the pharmacy. The Director of Nursing (DON) was interviewed on 9/23/22 at 5:10 PM and reported the following. She had not known there had been a problem with the Flonase prior to 9/23/22. She had looked into the issue on the current day (9/23/22) and learned that the Flonase had been filled on 9/1/22 with a 30 day supply. It was pulled during an audit. When the nurses tried to reorder it, then the pharmacy would have noted it was too soon to refill it. The pharmacy was supposed to fax this information to her so that she could resolve the issue, but she had never received a fax from the pharmacy that the nurses were trying to reorder the Flonase and that the pharmacy could not send it. The nurses had also not alerted her there was a problem. According to the DON it was her expectation that the nurses should have let her know that there was a problem with the Flonase.	F 755		