STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT MILLS RIVER	5593 OLD HAYWOOD ROAD MILLS RIVER, NC 28759

(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 survey were conducted on 11/28/21 through 12/01/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# GB3C11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint survey were conducted from 11/28/22 through 12/01/22. Event ID #GB3C11. One complaint allegation was investigated and it was substantiated. Intake NC00193704 was investigated and resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews with residents and staff the facility failed to assess the capability of residents to self-administer medications for 2 of 2 residents reviewed for self-administration (Resident #9 and #17).	F 554	F554 Facility failed to assess the capability of residents to self-administer medications for 2 of 2 residents reviewed for self-administration (Resident #9 and Resident #17).	12/26/22

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

Electronically Signed | 12/21/2022

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F 554	Continued From page 1 The findings included: 1. Resident #9 was admitted to the facility on 11/10/22. Review of the admission MDS dated 11/16/22 revealed Resident #9 was assessed as being cognitively intact. Review of the physician orders revealed none were in place for lubricating eye drops. Review of the medical records for Resident #9 revealed there was no documentation or assessment to show the resident was safe to self-administer medications. An observation and interview were conducted on 11/28/22 at 11:09 AM with Resident #9. In the room on the bedside table was a box labeled lubricating tear eye drops. Resident #9 stated she self-administered 1 drop in each eye twice a day and explained the drops weren't prescription and just used for moisturizing. A second observation and interview were conducted on 11/29/22 at 12:08 PM. Resident #9 revealed she hadn't requested to self-administer the eye drops and was told by someone yesterday, she didn't recall, not to leave the eye drops out in the open and showed the item was stored in the top drawer of the nightstand. Resident #9 revealed no one at the facility had asked her about self-administering or checked to ensure she was able to do so. Resident #9 revealed she used the eye drops at home and indicated she was able to self-administer.	F 554	Corrective Action: On 11/29/22, resident #9 and resident # 17 were interviewed by the Director of Nursing and asked if they would like to self-administer medications while in the facility. Both residents declined self-administration and declined the request for an MD order for the medications. Medications were removed from each resident□s room on 11/29/22 after the interview and stored until discharge. On 11/30/22 a call was placed to family members of each resident, and they were educated on the expectation on bringing medications into the facility by the Director of Nursing. Systemic Change: On 12/05/22, a 100% audit was completed by the Assistant Director of Nursing and Unit Manager of each resident□s room for medications at bedside. Two additional residents were found to have eye drops at their bedside. Each resident declined self-administration and an MD order for the eye drops. All alert and oriented residents were educated on the choice to self-administer medications while in the facility on 12/16/22 by Director of Nursing. One resident chose to self-administer. Education provided to resident families between the dates of 12/20/22 and 12/26/22 by facility Administrator/designee on the expectation on bringing medications into the facility. Education provided to Department Managers on room round expectations in relation to medications at bedside on 12/16/22 by Administrator. Education was	

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F 554	Continued From page 2 An interview was conducted on 11/29/22 at 12:19 PM with Nurse #1. Nurse #1 confirmed she was assigned to administer medications for Resident #9 but hadn't worked this assignment for the past couple of weeks. Nurse #1 revealed she didn't notice the eye drops in Resident #9's room and stated anytime a resident wanted to keep those in their room a physician's order would need to be in place to self-administer. Nurse #1 revealed she wasn't sure if an assessment was needed before a resident could self-administer medications and sometimes a resident or Family Member brought those items in, and staff weren't aware of it. During an interview on 12/01/22 at 10:54 AM the Nurse Practitioner (NP) revealed if medications were kept at the resident's bedside, she would expect a physician's order would be in place to self-administer. The NP revealed staff usually told her when a resident wanted to use eye drops, they did at home, and she would assess their ability to self-administer. An interview was conducted on 12/01/22 at 4:44 PM with the Director of Nursing (DON). The DON revealed a physician's order should be in place for a resident to self-administer eye drops and their ability to self-administer would be assessed before left in the room. An interview was conducted on 12/01/22 at 5:01 PM with the Administrator. The Administrator stated he expected over-the-counter medications were not stored in a resident's room. The Administrator revealed room checks were done regularly and if those items were missed the residents didn't have it very long. 2. Resident #17 was admitted to the facility on	F 554	provided to nursing, therapy, housekeeping, and dietary staff on the choice of Self-Administration and the expectation on what do if medications are found at the bedside between the date of 12/16/22 and 12/23/22. Education was provided by department heads after being educated by Administrator. Staff could not work prior to being educated. Education will be added to the general orientation after 12/23/22. The plan of correction was completed 12/26/2022. Monitoring: The Director of Nursing or designee will conduct an audit weekly of 10 resident rooms to ensure no medications at bedside. Any variances will be addressed at that time. This audit will be conducted weekly for 4 weeks, then monthly for 2 months. Room rounds were updated 12/21/22 with an additional line □Are there medications in plane view?□. Rooms rounds will be reported to the Administrator and monitored for three months. The Administrator will report on this Plan of Correction (POC) to Quality Assurance Performance Improvement (QAPI) committee monthly until the POC is completed. Recommendations for changes to the POC will occur if the facility is not maintaining compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance.	

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F 554	Continued From page 3	F 554		

11/05/22.

Review of the admission Minimum Data Set (MDS) dated 11/11/22 revealed Resident #17's cognition was assessed as being moderately impaired.

Review of the physician orders for Resident #17 revealed none were in place for eye supplements or lubricating eye drops.

Review of the medical records for Resident #17 revealed there was no documentation or assessment to show the resident was safe to self-administer medications.

During an observation and interview on 11/28/22 at 11:51 AM a clear zip lock plastic bag was placed on the top of a small refrigerator in the room of Resident #17. The bag contained a bottle of over-the-counter vitamin and mineral eye supplement capsules and a 10-milliliter bottle of over-the-counter lubricating eye drops. Resident #17 revealed a Family Member brought the supplements and eye drops to him and he was supposed to take those each day and would self-administered both the supplements and eye drops.

A second observation and interview were conducted on 11/29/22 at 12:27 PM. The supplements and eye drops remained in a clear plastic bag on top of the refrigerator in Resident #17's room. Resident #17 confirmed no one from the facility had assessed his ability to self-administer and no one from facility was involved with him taking the over-the-counter supplements or eye drops.

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An observation and interview were conducted on 11/29/22 at 3:25 PM with Nurse #1 and Resident #17. Nurse #1 observed the bottle of supplements and eye drops in same location. Nurse #1 asked Resident #17 if he had taken those and the resident responded yes but not every day. Resident #17 explained a Family Member brought the items into the facility and gave to him to take. Nurse #1 explained to Resident #17 a physician's order was needed to self-administer and he couldn't take those without one. Resident #17 agreed to let Nurse #1 remove the supplements and eye drops from the room and store in locked area. Nurse #1 confirmed there was no physician's order for the supplements or eye drops and no order for Resident #17 to self-administer.

During an interview on 12/01/22 at 10:54 AM the Nurse Practitioner (NP) revealed if medications were kept at the resident's bedside, she would expect a physician's order would be in place to self-administer. The NP revealed staff usually told her when a resident wanted to take a supplement or use eye drops, they took at home, and she would assess their ability to self-administer.

During an interview on 12/01/22 at 4:44 PM the DON revealed it was the facility's policy when a resident wanted to self-administer medications including supplements or eye drops a physician's order should be in place. The DON revealed before a resident could self-administer an assessment of their ability was done before those items were left in the room.

An interview was conducted on 12/01/22 at 5:01 PM with the Administrator. The Administrator

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F 554	Continued From page 5 stated he expected over-the-counter medications were not stored in a resident's room. The Administrator revealed room checks were done regularly and if those items were missed the residents didn't have it very long.	F 554		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the area of functional status for 1 of 12 sampled residents reviewed for MDS accuracy (Resident #22). Findings included: Resident #22 was admitted to the facility on 03/25/19. His diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or loss of strength on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side. The Hospice plan of care, revised 04/11/22, for Resident #22 revealed a care plan in place to address a problem of area of pain due in part to "contractures in bilateral legs and arms." Interventions included: pillow to support limbs and rolled washcloth in hand due to contracture. The quarterly MDS assessment dated 08/09/22 revealed Resident #22 required extensive to total staff assistance with all activities of daily living	F 641	F641 Facility failed to accurately code Minimum Data Set (MDS) assessments in the area of functional status for 1 of 12 sampled residents reviewed for MDS accuracy (Resident #22). Corrective Action: Resident #22□s MDS assessments dated 8/9/22 and 11/9/22 were modified on 12/01/2022 to reflect accurate coding in section G0400A and G0400B Functional Limitation in Range of Motion on the MDS. Systemic Change: All current residents on census as of 12/14/2022 were audited for the following: Accuracy of G0400A and G0400B Functional Limitation in Range of Motion. These audits were completed by the Regional MDS Manager 12/14/2022. Any errors noted were corrected by 12/16/2022. MDS Coordinator was educated by the Regional MDS Manager on 12/02/2022. This education includes accurate coding of functional limitations in range of motion.	12/16/22

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F 641	Continued From page 6 and had no impairment in the upper or lower extremities. The quarterly MDS assessment dated 11/08/22 revealed Resident #22 required extensive to total staff assistance with all activities of daily living and had no impairment in the upper or lower extremities. During an interview on 12/01/22 at 09:15 AM, the MDS Coordinator explained Resident #22 was receiving restorative therapy and had some movement in his upper and lower extremities which was why she marked no impairment when completing the MDS assessments dated 08/09/22 and 11/08/22. The MDS Coordinator confirmed Resident #22 did have contractures of both the upper and lower extremities with limited range of motion. She stated based on the Resident Assessment Instrument manual (instructional guidelines), the MDS assessments should have been coded to reflect Resident #22 had impairment in both the upper and lower extremities and modifications would be submitted. During an interview on 12/01/22 at 4:50 PM, the Administrator confirmed Resident #22 had contractures in both the upper and lower extremities and stated he would expect for the MDS assessments to be completed accurately.	F 641	This education will be included on any new MDS staff hired at the time of orientation. The completion date for this Plan of Correction is 12/16/2022. Monitoring: The Regional MDS Manager /designee will complete 5 MDS audits weekly for accurate coding G0400A and G0400B Functional range of motion for 4 weeks, then 2 chart audits weekly for 4 weeks, then 5 chart audits for 1 Month. The Administrator will report on this Plan of Correction (POC) to Quality Assurance Performance Improvement (QAPI) committee monthly until the POC is completed. Recommendations for changes to the POC will occur if the facility is not maintaining compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 7 §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 observations, record review, review of manufacturer's instructions, Nurse Practitioner, family and staff interviews, the facility failed to ensure securement was according to manufacturer recommendations for providing a safe facility van transport when a resident fell out of the wheelchair onto his side on the floor of the van resulting in minor abrasions and bruising to his face, arm and side for 1 of 2 residents reviewed for accidents (Resident #22). The findings included: Review of the manufacturer's instructions for the "QRT-1 Series", which is the system used on the facility's transport van to secure residents who are seated in wheelchairs during transport, specified in part: "B. Secure Passenger: 1. Attach lap belts by using integrated stiffeners to feed belts through opening between seat backs and bottoms and/or armrests to ensure proper belt fit around occupant. 2) Attach shoulder belt by extending the belt over the passenger's shoulder, across upper torso and fasten pin connector onto the lap belt. Note: Combination lap/shoulder belts serve as both window-side lap belt and shoulder belt. 3) Ensure belts are adjusted as firmly as possible but consistent with user comfort. Warning: Lap and shoulder belt should not be held away from the passenger's body by wheelchair components or parts such as the wheelchair's wheels, armrests, panels, or frame. Ensure belt webbing is not twisted while	F 689	Past noncompliance: no plan of correction required.	

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being worn by passenger. Belts should always bear upon the bony structure of passenger's body and be worn low across the front of the pelvis, with the junction between lap and should belts located near the passenger's hip."

Resident #22 was admitted to the facility on 03/25/19. His diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or loss of strength on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side.

The quarterly Minimum Data Set (MDS) dated 11/08/22 assessed Resident #22 with modified independence for daily decision making. His speech was unclear but was usually understood and usually able to understand others. He required extensive to total staff assistance with all activities of daily living and had no impairment of the upper and lower extremities. The MDS indicated Resident #22's height was 70 inches and he weighed 182 pounds.

A staff progress note dated 09/14/22 at 3:45 PM written by the Director of Nursing (DON) read in part, "Nursing staff notified Resident #22 fell out of wheelchair. Resident #22 observed lying on floor on left side and left posterior upper arm. Assessment by Registered Nurse reveals Resident #22 noted to have cut on left side of face and complaining of back pain. NEURO (relating to the nerves or nervous system) checks within normal limits. Nurse Practitioner (NP) assessed resident. Orders received to transport to Emergency Department (ED) for evaluation. Resident #22's spouse aware of incident. Emergency Medical Services (EMS) notified and transported Resident #22 to the hospital."

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An interview was attempted with Resident #22 on 11/28/22 at 11:56 AM with his spouse at bedside. Resident #22 remained non-verbal and did not answer questions. Resident #22's spouse reported in September 2022, Resident #22 was being transported back to the facility from a dental appointment and when they arrived at the facility, the Director of Nursing (DON), Assistant Director of Nursing (ADON) and other staff were all waiting out in front of the building. She recalled as she was walking toward the van, she noticed through the window that Resident #22's wheelchair was upright but she did not see him and was thinking he had a heart attack. When she got to the door of the transportation van, the ADON and DON were already in the van and Resident #22 was on the floor. Resident #22's spouse recalled his wheelchair was still in an upward position and anchored to the floor at the back of the van and Resident #22 was lying on his side with his head next to the seat toward the front of the van. She recalled Resident #22 was examined in the transportation van by the NP who told staff not to move him and have him transported to the hospital by EMS for evaluation. Resident #22's spouse stated when they had left the dental appointment, she did not watch Nurse Aide (NA) #1 (the facility's transportation driver) secure him into the van. She was not sure how he was able to fall out of his wheelchair as he was very contracted and couldn't straighten his legs or at what point during transport he actually fell. She stated due to the fall, Resident #22 sustained a cut on the left side of the face/cheek that turned into a black eye and cut on his upper left arm. Since the incident, she spoke with the Administrator who stated it was an accident and after several conversations, neither he or the

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facility's Insurance Adjuster had been able to explain how or when Resident #22 fell during transport. She added the Administrator did tell her they had a plan of correction and NA #1 was reassigned back to the floor as a Nurse Aide. Also, she stated the facility had the Occupational Therapist (OT) assess Resident #22's wheelchair and they wanted to purchase Resident #22 a "restraint vest" to wear during transport as an extra safety measure.

During a telephone interview on 11/29/22 at 12:17 PM, NA #1 stated she was the facility's transportation driver from March 2022 to September 2022 until she left the facility for other employment. NA #1 confirmed she was driving the transportation van on 9/14/22 when Resident #22 fell out of his wheelchair during transport. NA #1 explained she had transported Resident #22 to a dental office not far from the facility and after his appointment, she loaded him into the transportation van, attached the floor retractor hooks to the frame of his wheelchair and then secured the shoulder/lap belt across his chest and lap, pulled on the straps twice to make sure they were secure, and then proceeded to transport him back to the facility. She recalled when they were "about 1 ½ minutes" from the facility as she was slowing down to stop at the stop sign before making a turn, she heard a "thud" sound and when she turned around to look, Resident #22 was on the floor. She explained he had fell forward out of his wheelchair, landing on his side with his head next to the seat toward the front of the van. NA #1 stated she immediately called the facility to inform them what happened and asked staff to meet her out front of the building. NA #1 stated she was not sure how Resident #22 fell from the

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wheelchair and restated she had made sure he was secured in his wheelchair before starting transport, the shoulder/lap belt did not "budge" when the straps were pulled and the only thing that she could think might have happened was that the shoulder/lap belt must not have locked properly. NA #1 added Resident #22 was not on the floor long before she got him back to the facility, "only a matter of minutes" and when she arrived at the facility, the DON and other staff were waiting outside. NA #1 stated later that day, the Administrator and DON asked her to explain what had happened but did not have her do a reenactment of how she loaded and secured Resident #22 into the transportation van. NA #1 stated the following day (09/15/22), she received reeducation from the Maintenance Director regarding proper securement when transporting residents in the facility van.

The NP progress note dated 09/14/22 revealed in part, "asked to come outside to transport van to assess Resident #22. Resident #22 observed lying on his left side on the floor of the van. Resident #22 verbalizes 'mmhmm" which equals 'yes' to back and head pain. Left cheek area with small abrasion and bleeding. Unable to obtain vitals due to positioning ...normocephalic (referring to a head of normal shape and size) appearing and to palpation (touch) ...bilateral contractures of the extremities ...no neurological appearing acute deficits, responds to spouse and answers questions in his own usual way ...Assessment/Plan: fall from wheelchair during transport returning from dental appointment. Instructed nursing staff to stabilize Resident #22's head and not to move given complaints of back and head pain. Send to Emergency Department (ED) for further evaluation."

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During an interview on 12/01/22 at 10:28 AM, the NP recalled on 09/14/22, staff came into the facility to get her and ask her to come out to the transportation van to assess Resident #22. She stated when she got outside, the side door of the van was open and she had a clear visual of Resident #22 who was lying on his left side on the floor with his head up toward the front of the van. The NP stated she was not sure how Resident #22 fell out of his wheelchair and thought maybe his wheelchair was positioned in the middle of the van but couldn't really state for sure where it was located as her main focus at the time was to ensure Resident #22 was ok. She recalled Resident #22 was alert and able to say "mmhmm" to questioning, had a small abrasion on his cheek that was bleeding and he complained of pain so she told staff not to move him and call EMS to transport him to the hospital for evaluation.

The EMS report dated 09/14/22 noted upon arrival at the skilled nursing facility, Resident #22 was lying on his left side in the transportation van. The EMS report read in part, "Per staff on scene, it is unknown how long the patient has been laying in the back of the van and when the van arrived at their facility, the patient was on the floor. Patient noted to be conscious, alert and oriented to his normal per family on scene. Patient noted to be non-verbal. Patient noted to be complaining of pain in his lower back. Unable to place the patient in a C-collar (medical device used to support the neck) due to the patient having a short neck. Stabilized the patient's neck via manual c-spine and rolled patient onto his back. Patient noted to have a laceration to the upper posterior area of his left arm from where he

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laid on a latch in the back of the van and an abrasion below his left eye. Placed the patient on a backboard and carried him to the stretcher. Wrapped the patient's laceration to his arm, placed towels around the patient's head for stabilization and transported to the hospital."

The ED physician progress note dated 09/14/22 read in part, "History: Patient arrives via EMS due to injury. Patient with a history of intracerebral hemorrhage (type of stroke caused by bleeding within the brain tissue) three and a half years ago which has left patient completely bedridden and contracted. Spouse at bedside states that he left his dentist appointment and was placed in the transportation van but when they arrived at the facility everybody came rushing out of the facility to the van. When she got to the van, she found Resident #22 on the floor of the van on his left side. Wheelchair was still strapped in the back of the van. Patient arrives with an abrasion to the left cheek and to the left upper arm. There are abrasions and bruising noted to the left lateral side and left hip area. Patient is able to answer yes and no questions. Complains of pain to the lumbar spine with palpation as well as to the left hip with palpation. Patient is contracted with legs bent towards the torso, unable to fully extend. Assessment/Plan: skin tears cleaned and bandages applied. Skin tear to left inner arm consistent with sliding on floor." It was further noted x-rays conducted on 09/14/22 of Resident #22's lumbar spine and left hip were negative for acute fractures. Resident #22 was discharged from the hospital on 09/14/22 back to the skilled nursing facility in stable condition.

A staff progress note dated 09/15/22 at 8:00 AM written by the Assistant Director of Nursing

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(ADON) read in part, "Resident #22 awake and alert per baseline this AM with spouse at bedside. Skin assessment reveals skin tear to left upper posterior arm approximately 2 centimeters (cm) x 1 cm x 0.1 cm with scant serous drainage (thin, watery and clear substance exiting the wound), no redness, no odors. Left uppermost posterior arm presents with superficial abrasion approximately 5 cm x 1 cm x 0 cm without drainage, no redness or signs of infection. Left elbow with superficial abrasion approximately 1 cm x 1 cm x 0 cm, no redness or drainage. Light purple/red bruising to left forearm approximately 2.5 cm x 2 cm x 0 cm, skin intact. Left facial cheek presents with superficial abrasion approximately 0.25 cm x 1 cm x 0 cm, no drainage or redness. Chin presents with superficial abrasion approximately 0.2 cm x 0.3 cm x 0 cm, no drainage, no redness. Resident #22 status post fall from yesterday 9/14/22 without any latent injuries observed, moves all extremities within baseline, neuro checks in place and ongoing, within normal limits per baseline. Resident #22 complains of general mild discomfort with new order for Tylenol 500 milligrams (mg) 2 tablets every 6 hours as needed for pain/discomfort administered. Vital signs stable, no signs/symptoms of distress."

During an interview on 11/30/22 at 9:17 AM, the Assistant Director of Nursing (ADON) stated on 09/14/22, when he went outside to the front of the building with the DON, he saw the transportation van coming up the road with Resident #22's spouse following the van in her car. As soon as the van parked, he and the DON opened the side door and saw Resident #22 lying on the floor on his left side. The ADON stated Resident #22 was alert and appeared calm and upon assessment

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he didn't have any significant bleeding, however, they decided not to move him as they weren't sure if he had any injuries that were not visible and wait for EMS to arrive to get him on the backboard to take him to the hospital for further evaluation. The ADON stated when he opened the door of the van, Resident #22 was lying on the floor in front of his wheelchair that was still secured to the floor van with his head next to the seat toward the front. He stated the wheelchair was still in an upright position and the shoulder/lap belt was pulled from the side with the strap caught around the armrest on the left side of the wheelchair and was not sure what happened or how it came loose. The ADON stated Resident #22 did not have any "purposeful" movement, was contracted and would not have been able to use his hands to unbuckle the shoulder/lap belt.

During an interview on 12/01/22 at 2:26 PM, the Maintenance Director recalled on 09/14/22, he was in the maintenance building behind the facility when he got a call and was told to come to the front of the facility with tools to remove the front seats of the transportation van. He stated when he arrived, staff were outside by the van, the side door was open and he saw Resident #22 on the floor of the van lying on his left side with his head up toward the driver's seat. The Maintenance Director recalled he had to remove Resident #22's wheelchair from the transport van for EMS to get into the van to assist Resident #22. He recalled Resident 22's wheelchair was in an upright position, the shoulder/lap belt was not engaged and the floor securement retractor straps were intact and connected to the frame of the wheelchair. The Maintenance Director stated the van was placed out of service pending a

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safety inspection from an outside company; however, he also checked the securement system thoroughly and found nothing out of the ordinary. The Maintenance Director confirmed he provided NA #1 with reeducation on wheelchair securement after the van accident involving Resident #22 which included NA #1 providing a return demonstration. In addition, he had since trained the new facility transportation driver that also included a return demonstration for proper securement.

An observation of the facility transportation van and follow-up interview was conducted with the Maintenance Director on 12/01/2 at 2:40 PM. The facility transportation van was a mid-size van with a lift located at the back of van. When the side door on the right side of the van was opened there were 2 shoulder/lap belts (approximately a wheelchair apart) attached to the roof of the van on the left side of the van, 2 buckle straps on the right side for the shoulder/lap belt to connect to when pulled across the resident seated in the wheelchair and on the floor were retractor with straps that had hooks to connect to the bottom of the wheelchair frame. The Maintenance Director stated on 09/14/22, Resident #22's wheelchair was positioned in the middle of the van toward the back closest to the lift. From the wheelchair to the seat (pushed up flush to the back of the driver's seat) was approximately 2 feet of space which was where he stated Resident #22 landed when he came out of the wheelchair onto his left side. He explained Resident #22's head was close to the seat located directly behind the driver's seat, up next to the left wall of the van and there was a floor retractor that Resident #22's left arm landed on. The Maintenance Director stated when he first observed Resident

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#22's wheelchair and removed it from the transportation van, the shoulder/lap belt was not engaged. He explained the buckle strap to the right of the wheelchair was lying on the floor, the shoulder/lap belt was positioned to the left "at home base" which he described as not pulled from its original position and the shoulder/lap strap was not caught on the arm rest of the wheelchair.

A joint interview was conducted with the Administrator and DON on 11/29/22 2:00 PM. The DON stated she was informed by facility staff that NA #1 was on her way back to the facility and had called to report Resident #22 had fallen out of his wheelchair during transport. The DON stated she called the Administrator to notify him of the situation as she walked outside to meet NA #1 upon their arrival and less than 5 minutes passed before the transportation van pulled up to the facility. The DON recalled when she and the ADON opened the side door of the van, Resident #22 was lying on his left side on the floor. Upon assessment, she stated Resident #22 was alert and responding per his baseline. The DON explained the way Resident #22 was lying on the floor it appeared as if he somehow leaned forward toward the front of the van and came out of the wheelchair. She added Resident #22 was not able to move his upper extremities on command but would move around at times, although very limited. The DON recalled NA #1 was very distraught and trying to explain what happened but the DON could not recall what NA #1 said as her main concern at the time was ensuring Resident #22 was ok. The DON stated when she assessed Resident #22 she noticed a small laceration on his left cheek that was bleeding and a skin tear on his upper arm. She

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added the NP also assessed Resident #22 the best she was able given his positioning on the floor of the van. She stated Resident #22 was not moved or repositioned until EMS arrived to transport him to the hospital and as EMS got him on the backboard she observed other abrasions to his arm where he had laid on the floor. The DON restated her focus was on Resident #22 and did not observe the securement of his wheelchair but did state the shoulder/lap belt was not on Resident #22 when he was on the floor of the transportation van.

A joint interview continued with the Administrator and DON on 11/29/22 2:00 PM. The Administrator stated he was not at the facility when notified by the DON that NA #1 had called the facility to report Resident #22 had fallen out of his wheelchair during transport. By the time he arrived back to the facility, the transportation van was already parked at the front of the building and staff were outside assessing the situation. The Administrator recalled Resident #22's wheelchair was positioned upright and the floor securement retractors were attached to the frame of the wheelchair. The Administrator stated immediately after Resident #22 was transported to the hospital, he and the DON sat down with NA #1 to ask her what happened and she had described the steps she had done to ensure Resident #22 was secured in his wheelchair prior to transport. The Administrator stated they did not have NA #1 conduct a reenactment of how she secured Resident #22 into his wheelchair and explained she had been in the position since February 2022 and transported a lot of residents to outside appointments without incident. The Administrator stated they were unable to determine the root cause of Resident #22's fall

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and explained maybe the movement of the transportation van caused the shoulder/lap belt to come loose or the buckle malfunctioned. He added it was hard to determine what actually happened as Resident #22 could not tell them and they only had NA #1's account of the incident.

During a follow-up interview on 11/29/22 at 3:50 PM, the Administrator explained after the incident on 09/14/22, they implemented a plan of correction which included placing the facility transportation van out of service until thoroughly checked by an outside company, utilizing an outside transportation company for resident appointments until the facility van was placed back into service on 09/21/22 and monitoring systems for ensuring a safe transport. He added NA #1 did not do any further transport and the new Transportation Driver was educated on proper securement by the Maintenance Director, who was also the backup transportation driver.

On 11/29/22 at 4:44 PM, the Administrator and Director of Nursing were notified of Immediate Jeopardy.

The facility provided the following Allegation of Compliance with the correction date of 09/15/22:

Based on incident dated 09/14/22, Resident #1 was being transported back to the facility from a dentist appointment when Resident #1 slid out from his wheelchair to the floor of the van.

1. For the Resident affected: Driver notified facility immediately. Resident #1 was not moved from his position until Emergency Medical Services (EMS) arrived. Nurse Practitioner was notified and assessed Resident #1. Orders

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received to transport Resident #1 to the Emergency Department for evaluation. Resident #1 was transported to the hospital by EMS.

2. For the Residents with the potential to be affected: Services were immediately suspended with facility transportation by the Administrator on 09/14/22 pending investigation of the incident. The transportation van was taken to an outside company first thing on the morning of 09/15/22 for a full safety inspection. The driver was re-educated on 09/15/22 upon returning to work on Van Safety and Van lift check off. Additionally, transportation drivers were educated on defense driving on 09/15/22. Resident #1's wheelchair was screened for positioning by the building's Occupational Therapist.

3. Systematic Change: Education was provided to all in-house transport drivers by the Administrator on the proper securement of residents while riding in a wheelchair accessible van on 09/15/22. Education included pre-securement steps, securement steps, and final check sections. Safety inspection sheets will be used and monitored by facility designee.

4. Monitoring: Facility designee will observe loading and unloading of resident to ensure proper securement of residents in the vehicle. Also, safety inspection sheets will be monitored by facility designee. Audit will be done 3 days a week times 2 weeks, then 2 days a week times 2 weeks, then two times a week times 2 months. Additionally, Resident #1 will be assigned a designee to ride with them on their next 5 transportations to ensure Resident #1's positioning is secure.

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F 689	Continued From page 21 Starting on 09/15/22, data obtained during the auditing process will be analyzed for patterns and trends and reported to the Quality Assurance and Performance Improvement (QAPI) by the Administrator monthly for two months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Alleged date of compliance: 09/15/22. The facility's Allegation of Compliance was validated from 11/29/22 to 12/01/22 and concluded the facility implemented an acceptable corrective action plan effective 09/15/22. It was confirmed all authorized drivers were trained on wheelchair securement and a transport driver skills assessment was completed with NA #1 by the Maintenance Director on 09/15/22. The facility provided documentation that included monthly safety inspections of the facility transportation van, Transport Drivers training and facility audits. The transportation audit sheets that were started on 09/21/22 when the facility transportation van was placed back into service were reviewed with no concerns identified and remained ongoing. Residents who were transported to outside appointments were interviewed and reported no concerns. Facility staff were interviewed and confirmed they received training on transportation safety that included how to properly secure a resident in the wheelchair and perform return demonstrations. The corrective action plan was reviewed by QAPI on 10/21/22 and 11/17/22.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		12/19/22

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F 695	Continued From page 22 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Nurse Practitioner (NP) interviews the facility failed to follow the Physician order for the use of supplemental oxygen for 1 of 2 residents reviewed for respiratory care (Resident #191). Findings included: Resident #191 was admitted to the facility 11/22/22 with diagnoses including chronic obstructive pulmonary disease (abbreviated as COPD and meaning a condition involving constriction of the airways and difficulty breathing) and respiratory failure (a condition in which the lungs have difficulty loading the blood with oxygen or removing carbon dioxide). Resident #191 had a Physician order dated 11/22/22 for oxygen at 2 liters per minute via nasal cannula (a tube in the nose) to maintain saturations (the amount of oxygen in the blood) above 90%. The admission Minimum Data Set (MDS) dated 11/29/22 revealed Resident #191 was cognitively intact and used oxygen.	F 695	F695 Facility failed to follow the Physician order for the use of supplemental oxygen for 1 of 2 residents reviewed for respiratory care (resident #191). Corrective Action: On 11/30/22, resident # 191 oxygen setting was corrected to follow Physician order. Systemic Change: On 12/05/22, 100% of all residents with oxygen orders were audited for correct oxygen settings by the ADON/Unit Manager. Any resident with inaccurate settings, were corrected immediately. On 12/15/22, the DON initiated an education for correct oxygen settings and usage to all Nurses.This in- service was completed on 12/19/22. Staff could not work prior to being educated. The completion date for this plan of correction is 12/19/22.	

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F 695	Continued From page 23 Review of a respiratory care plan initiated 11/29/22 revealed Resident #191 was at risk for impaired gas exchange related to the use of oxygen. Interventions included administering medications as ordered, administering oxygen as ordered, and monitoring oxygen as ordered and prn (as needed). Review of Resident #191's November 2022 Medication Administration Record (MAR) revealed her oxygen saturations ranged from 90-97%. An observation of Resident #191 on 11/28/22 at 10:40 AM revealed she was receiving oxygen via nasal cannula. An observation of Resident #191's oxygen concentrator at the same date and time revealed it was set to provide oxygen at 4 liters per minute. An observation of Resident #191 on 11/29/22 at 10:40 AM revealed she was receiving oxygen via nasal cannula. An observation of Resident #191's oxygen concentrator at the same date and time revealed it was set to provide oxygen at 3 liters per minute. An observation of Resident #191 on 11/30/22 at 09:37 AM revealed she was receiving oxygen via nasal cannula. An observation of Resident #191's oxygen concentrator at the same date and time revealed it was set to provide oxygen between 3 and 4 liters per minute. During an interview with Nurse #1 on 11/30/22 at 10:58 AM she confirmed Resident #191's oxygen was set between 3 and 4 liters per minute. She stated she usually checked to make sure the oxygen concentrator settings matched the oxygen	F 695	Monitoring: The Director of Nursing or designee will audit up to 5 residents, assuming there are 5 residents in the building with oxygen orders, 3 times weekly for 4 weeks for correct oxygen settings, then weekly for 4 weeks, then once for 1 month. The Administrator is responsible for implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. At which time, the determination will be made if further monitoring is necessary. Recommendations for changes to the POC will occur if the facility is not maintaining compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345253	A. BUILDING _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 24 orders each shift and she had not yet checked the oxygen setting for Resident #191 on 11/30/22. An interview with the Nurse Practitioner (NP) on 12/02/22 at 10:57 AM revealed she expected nursing staff to follow Physician orders for oxygen use. She stated if a resident required more oxygen than ordered she would expect to be notified so a new oxygen order could be obtained. An interview with the Director of Nursing (DON) on 12/01/22 at 04:41 PM revealed she expected staff to follow Physician's orders for oxygen use. She stated nurses should verify the oxygen concentrator was set correctly when they were in the resident's room checking vital signs. An interview with the Administrator on 12/01/22 at 05:07 PM revealed he expected staff to follow Physician orders for oxygen use.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		12/2/22

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F 812	Continued From page 25 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard dry food items that were past the use by date, opened, and ready for use in 1 of 1 pantry, failed to discard fresh vegetables with visible signs of spoilage in 1 of 1 walk-in refrigerator and failed to discard frozen food items with visible signs of freezer burn and ice accumulation stored in 1 of 1 walk-in freezer. This had the potential to affect food served to residents who resided in the facility. Findings included: An initial observation of the kitchen and concurrent interview was conducted with the Dietary Manager (DM) on 11/28/22 at 9:32 AM that revealed the following: Stored in the pantry and available for use was a clear plastic bag containing instant chocolate pudding mix labeled with a use by date of 06/11/22. The DM removed the bag of chocolate pudding from the pantry shelf and stated it should have been discarded 90 days after it had been opened. Stored in the walk-in refrigerator were approximately 12 fresh green peppers stored together in a cardboard box, open to air, with 3 green peppers that had visible signs of spoilage (mold, soft mushy spots and one with the bottom completely rotted). The DM removed the green peppers that were spoiled and explained she had looked through the box of green peppers	F 812	F812 Facility□s failure to discard dry food items that were past the use by date, opened, and ready for use in pantry; failure to remove fresh vegetables with visible sign of spoilage; and failure to discard frozen food items with visible signs of freezer burn were areas of concern. Corrective action: On 11/28/22 the facility dietary manager immediately discarded pudding mix labeled with an use by date of 06/11/22. She also removed three green peppers that had visible signs of spoilage. Furthermore, 5 frozen chicken tenders with visible ice crystallization and no open date were discarded. A second audit was completed in the kitchen on 11/30/22. All items identified were immediately discarded. Systematic Changes: On 11/30/22, the Dietary Manager and Registered Dietitian provided all dietary staff with education regarding storage requirements, expiration dating, and discarding of: expired, spoiled, and freezer burned foods. Staff were not allowed to work prior to being educated. Additionally, □Use By Date Procedures□ were posted on the bulletin board in the front of the kitchen and on the door of the	

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F 812	Continued From page 26 yesterday, discarded several and had just missed the ones at the bottom of the box. Stored in the walk-in freezer was a clear plastic bag containing approximately 5 frozen chicken tenders with visible ice crystallization inside the bag and on the chicken. The bag was unlabeled with no opened date. The DM removed and discarded the bag of frozen chicken tenders. The DM stated the bag of chicken tenders should have been dated when opened and discarded when observed with ice crystallization. A second observation of the kitchen and concurrent interview was conducted with the DM on 11/30/22 at 4:30 PM that revealed the following: Stored in the walk-in refrigerator were approximately 9 green bell peppers stored together in a carboard box, open to air, with 2 green peppers that had visible signs of spoilage (soft mushy spots and rotted areas). Also, a separate cardboard box on the same shelving unit contained 3 bags of celery. One of the bags of celery had visible brown, mushy spots on the bottom of the stalks. The DM removed the green peppers and celery that were spoiled and discarded them in the trash. Stored in the walk-in freezer was an unopened bag of frozen chicken portions that had noticeable freezer burn with ice crystallization on the inside of the bag. The DM removed the bag of chicken, stating it was unusable, and discarded the bag into the trash. During the same interview, the DM explained dietary staff were instructed to label food items with the date it was prepared and/or opened and	F 812	refrigerator and dry storage areas as a point of reference for staff to review. Additionally, all new employees will receive education on proper labeling, dating, and storage requirements. The plan of correction was completed 12/02/2022. Monitoring: The Administrator or designee will audit the dietary department to ensure expired items are discarded in the dry storage, freezer, and refrigerators. Additionally, the Administrator or designee will monitor the refrigerator for spoilage and the freezer for freezer burned items. The audits will be conducted daily Monday - Friday for four weeks, then three times a week for four weeks, then once a week for four weeks. The Administrator will review the audits weekly. The Administrator is responsible for implementing this Plan of Correction (POC) and reporting the findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly. The audits will be reviewed monthly by the QAPI Committee until the POC is completed. Recommendations for changes to the POC will occur if the facility is not maintaining compliance with regulatory requirements. The POC can be changed to include additional education and monitoring to obtain and maintain substantial compliance.	

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F 812	Continued From page 27	F 812		

the use-by-date as indicated on the Use-By-Date procedure posted in the kitchen. The DM added dietary staff were usually very good at following the posted procedure for labeling, dating and discarding expired food items and explained they just hadn't noticed the items that were identified during the observations conducted on 11/28/22 and 11/30/22. The DM stated it was the responsibility of all dietary staff to check the pantry, refrigerators and freezers daily to make sure food items were properly labeled and dated and discard any items that were spoiled or expired.

During an interview on 11/30/22 at 4:50 PM, the Administrator stated he would expect for food items to be labeled and dated when opened or prepared and discarded if they had visible signs of spoilage or were past the expiration and/or use-by-date.