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	345365	A. BUILDING _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF KINSTON	907 CUNNINGHAM ROAD KINSTON, NC 28501

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/10/23 through 7/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 28SI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/10/23 through 7/13/23. Event ID# 28SI11. The following intakes were investigated NC00194522, NC00194851, NC00194951, NC00195034, NC00195533, NC00196280, NC00197401, NC00204607, NC00199925, NC00200015, NC00202459, NC00202729, NC00202790, NC00204013, NC00204164, NC00204181. 1 of the 32 complaint allegations resulted in deficiency.	F 000		
F 557 SS=G	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to treat a resident (Resident #40) in a dignified manner as evidenced by searching her room without	F 557	1. Resident #40 received all of her money back along with a lock box and key to keep her personal items secure in her room on 6/26/23. There have been no	8/7/23

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

Electronically Signed | 08/02/2023

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F 557	Continued From page 1 permission on 6/24/23. Staff removed money found in her room and this caused Resident #40 to cry and to feel "helpless and powerless". The money was later returned to the resident. This was for 1 of 2 residents reviewed for dignity. The findings included: Resident #40 was admitted to the facility on 6/15/23 with diagnoses that included depression and anxiety. Resident #40's admission Minimum Data Set (MDS) assessment dated 6/22/23 indicated severe cognitive impairment. She had no mood symptoms and no indication of psychosis. The assessment indicated she had rejection of care daily. An interview was conducted with Resident #40 on 7/11/23 at 9:51 AM. She was oriented to person, place, time and situation. Resident #40 stated she was watching television while sitting in her wheelchair when two staff members came in and started going through her room on Saturday 6/24/23 after supper while she was watching television. She reported she believed it was two nurse aides but she was not sure. She reported they located cigarettes in a blue bag in her closet. The resident stated she is an occasional smoker and forgot the cigarettes were in her bag. She stated she did not care if the cigarettes were returned and had no issue with the facility keeping the cigarettes locked up. Resident #40 stated they discovered approximately $7,000 in her makeup bag which was in a drawer of her bedside table. Resident #40 stated she tried to get her makeup bag back but was unsuccessful. Resident #40 stated the staff member counted the money while on the phone with the	F 557	further searches of Resident #40 person, belongings, or room. As of 7/14/23 the facility Administrator at the time of the incident is no longer employed by Signature Healthcare of Kinston. 2. No other residents have had their person, room, or belongings searched as of 7/31/2023. The Social Service Director (SSD) and Department Managers completed an interview with all residents that have a BIMS of 8 or higher regarding resident rights to identify any concerns with searches without consent. This was completed by 7/11/23. All findings were investigated and reported to the appropriate regulatory agencies. 3. All staff in all departments have been educated by the Regional Clinical Nurse Consultant, SDC, Department Manager, and/or SDC on Resident Rights with emphasis on facility staff should not conduct searches of a resident or their personal belongings unless the resident or their representatives agrees to a voluntary search and understands the reason for the search. Obtain consent from the resident and/or resident representative to search the resident's body or personal possessions. This was completed on 7/19/23. " Any staff that has not received in-servicing will be contacted by phone and complete the in-servicing and sign the in-servicing sheet on their next scheduled day. " Any staff member not completing in-servicing by 8/2/23 in person or via the phone will be removed from the schedule until in-servicing is complete.	

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F 557	Continued From page 2 Administrator. She further stated she became very upset and cried because the money in question was her life savings. Resident #40 stated she went out in the hall and begged staff who were in the hall to give her the money back. She was unable to recall the specific staff members. She reported one of the staff members stated if she did not get back in her room and stop crying, she would be sent to a psychiatric ward. Resident #40 stated she could not remember which staff member threatened to send her to a psychiatric ward. Resident #40 stated she was scared due to this threat and returned to her room. She reported the staff told her they were taking her money to ensure it was not stolen. Resident #40 expressed frustration because she stated it was her money and it should be her decision if she kept the money in her room. Resident #40 reported the staff reminded her she was not allowed to have the cigarettes and lighter. She stated she felt very depressed at the thought of losing her money. Resident #40 stated she had this money so when she discharged, she would be able to have remodifications done to her home and pay for assistance as she just had a leg amputation. She stated she felt "very hopeless and powerless" in this situation. Resident #40 further stated she did not think it was right they (the staff) went into her room and began going through her things. She stated they did not ask her permission. She stated her money was returned to her by the Administrator on 6/26/23 and she was given a lockbox by Nurse #7 on 6/24/23. She pointed out the key to the lockbox on a stretchy cord on her wrist. Resident #40 stated she was her own Responsible Party. During a phone interview with Resident #40's	F 557	" All contracted staff will complete in-servicing at the beginning of their first shift with the facility. All in-servicing will be included in the Agency Orientation packet. This in-servicing will be completed by the Charge nurse, ADON, SDC, or DON. " All new Signature staff will be in-serviced and educated during general employee orientation by the SDC or department manager. 4. The Administrator or Designee will interview 5 residents a week for 3 months beginning on 8/2/23 regarding any concerns with Resident Rights and/or a search of their room, person, and/or belongings. The findings of these audits will be presented to the QAPI committee monthly. The QAPI committee will determine if compliance is met or if ongoing monitoring is required.	

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family member on 7/11/23 at 4:30 PM she stated she spoke with Resident #40 on 6/26/23, and she told her staff went in to check for drugs in her room. She stated Resident #40 reported two staff members took money from her. The family member further stated the resident reported she was told to stop crying or she would be sent to a psychiatric hospital. The family member stated she spoke with the Administrator on 6/29/23 and the Administrator admitted they should not have taken Resident #40's money. She stated she was not aware Resident #40 had $6400 in the facility.

During an interview with Nurse Aide (NA) #20 on 7/11/23 at 12:00 PM she reported on 6/24/23 a cup with zinc oxide (a cream utilized by staff when changing resident briefs) was found at Resident #12's bedside. It was inadvertently left at the resident's bedside. She reported staff completed room searches for all residents and were looking for medications and/or lotions at bedside. She stated Nurse #5 went in Resident #40's room. NA #20 stated Nurse #5 called her in Resident #40's room because she had found 6 lighters and 3 packs of cigarettes. Residents were not allowed to have lighters and cigarettes in their possession. She further stated Resident #40 had "a wad of cash" in her room which was in a pencil case. NA #20 stated Nurse #5 called the Administrator and the Administrator stated to remove the cash from her room. She further stated Nurse #5 counted the money out loud with the Administrator on the phone. NA #20 stated Nurse #5 tried to explain to Resident #40 they were taking the money and locking it up her money to ensure nothing happened to it. She stated Resident #40 did not seem to understand. She stated Resident #40 became upset and was

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screaming and crying. She stated they attempted to calm Resident #40 down without success. She further stated the Unit Coordinator was not scheduled to work that evening but she came in after the search was completed. She stated she witnessed the Unit Coordinator lock the money in her desk drawer. NA #20 stated the weekend charge nurse got a lock box and gave it to Resident #40. She reported she did not hear anyone threaten Resident #40 with psychiatric hospitalization.

An interview was conducted with Nurse #5 on 7/11/23 at 5:42 PM. She stated she came in to work on 6/24/23 and was told to search rooms by the Administrator and remove items residents were not supposed to have such as medications, illicit drugs and other contraband. Nurse #5 reported she and the two medication aides were instructed to perform the search. She stated they searched 100% of resident rooms and consent was not secured from residents or their responsible parties. Nurse #5 stated she was working based on the instructions given by the Administrator. Nurse #5 stated she found cigarettes and lighters in Resident #40's room. Nurse #5 reported residents were not allowed to have cigarettes and lighters in their room. She further stated she found a "pouch" in Resident #40's bedside table and looked in it when searching for medications. Nurse #5 stated she found $6400 in the pouch and contacted the Administrator. The Administrator instructed her to remove any contraband and the money from Resident #40's room. She reported she counted the money while the Administrator remained on the phone. Nurse #5 stated Resident #40 hit her and tried to run her over with her wheelchair. She stated Resident #40 was very upset and crying.

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Nurse #5 stated she was no knowledge of anyone threatening her with psychiatric hospitalization.

An interview was conducted with Nurse Aide (NA) #19 on 7/11/23 at 11:55 AM who stated she recalled the night of the search of resident rooms on 6/24/23. She stated she witnessed Nurse Aide #20, and a nurse (Nurse #5) go into Resident #40's room and was searching for cream. She explained Resident #12 had a cream inadvertently left at his bedside and they wanted to ensure no other residents had medications at bedside.

An interview was conducted with the Unit Coordinator on 7/11/23 at 1:00 PM. She stated she was not in the building when the search happened on 6/24/23. She reported she was called in afterwards by the Administrator to help count Resident #40's money. She further stated she believed the money was counted over the phone with the Administrator. The Unit Coordinator stated she placed $6400 in her desk drawer. The Unit Coordinator stated she was in the building from approximately 10:01 PM until 10:45 PM. She reported Resident #40 was very upset and was calling staff derogatory names. The Unit Coordinator stated she did not hear anyone threaten Resident #40 with psychiatric hospitalization. She indicated the cigarettes and lighters were locked in the nurses' station because residents were not allowed to keep smoking materials.
An interview was conducted with Nurse #7 on 7/11/23 at 2:45 PM who stated he was not involved with the searching of resident rooms on 6/24/23. He stated Resident #40 was very upset when he entered the building after 9:00 PM on

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6/24/23. Nurse #7 reported he spoke with her and she stated staff forcibly took her money. He stated he took Resident #40 outside to smoke to calm down. Nurse #7 stated he provided her with a lockbox and showed her how to use it.

During an interview with the Administrator on 7/11/23 at 2:15 PM she reported on 6/24/23 she instructed staff were to search resident rooms for medications at residents' bedside and other contraband. She explained she was notified on 6/24/23 a resident had become ill and they located a zinc oxide cream at his bedside. The Administrator stated she instructed Nurse #5 and two medication aides to search 100% of resident rooms. She stated no consents were obtained. She stated any actions taken by staff members were at her instruction. The Administrator stated when she spoke with the Regional Nurse Consultant after the search on 6/24/23, she was told it should have not been a full search but just to check on room surfaces that no medications were at bedside.

An interview was conducted with the Regional Nurse Consultant on 7/11/23 at 3:15 PM who stated she spoke with the Administrator by phone on the evening of 6/24/23 and was told about staff confiscating Resident #40's money. She indicated she told the Administrator the money had to be returned. She reported earlier in the day on 6/24/23 when she was informed of a resident possibly ingesting zinc oxide cream she instructed the Administrator for staff to check resident rooms for medications. The Regional Nurse Consultant stated it was her expectation staff would check surfaces for similar medications, not search closets and drawers. She indicated that the staff should not have

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F 557	Continued From page 7 conducted full room searches without consent unless there was reasonable suspicion of contraband or property belonging to another person. She further indicated it is a resident rights' issue to enter a resident's room and begin a search without permission. During an interview with the Vice President of Clinical Operations on 7/11/23 at 3:30 PM she reported Resident #40's money should not have been taken from her without her permission. She indicated she believed the Administrator did not understand the facility policy. The Vice President of Clinical Operations indicated the situation of medications at a resident's bedside did not warrant a 100% search for contraband in resident rooms according to facility protocol. She indicated residents have the right to possessions and the facility cannot search without a reasonable suspicion of contraband or another resident's property. The Vice President of Clinical Operations reported Resident #40's money should not have been removed from her possession.	F 557		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607		8/7/23

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F 607	Continued From page 8 paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews, the facility failed to implement their abuse policy and procedure in the following areas: administration reporting allegations of abuse within two hours to the state agency from the time of notification of the alleged abuse incident (Resident #76 and Resident #40) and completing a thorough investigation that included assessments of all residents for abuse and statements from all residents and involved staff for an allegation of abuse (Resident #40, Resident #7, and Resident #15) for 4 of 7 residents reviewed for abuse. Findings included: The facility's "Abuse, Neglect and Misappropriation of Property" policy dated 10/17/2022 stated any abuse allegation must be	F 607	1.a. On 7/7/23 resident# 76 was assessed by a licensed nurse with no injuries noted. On 7/7/23 Nurse #4 was educated on the importance of timely reporting of allegations of resident abuse and removing alleged perpetrator immediately from premises until the completion of investigation. This education was completed by Regional Nurse Consultant. b. On 5/17/23 resident # 15 was assessed by licensed nurse with no injuries noted. On 5/17/23 the facility moved resident #15 to a new location in the facility where she felt safe. Resident# 7 was provided a	

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F 607	Continued From page 9 reported to state within 2 hours from the time the allegation was received, and any reasonable suspicion of a crime plus serious bodily injury must be reported to the state and police. The investigation guidelines stated the facility's administrator will investigate all allegations, reports, grievances and incidents that potentially could constitute "allegations of abuse" and may delegate some or all of the investigation as appropriate but retains the ultimate responsibility to oversee and complete the investigation and to draw conclusions regarding the nature of the incident. The investigation should include interviews of involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations and to the extent possible and applicable, provide complete and thorough documentation of the investigation. The facility administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents. c substantiated allegation of abuse will be reviewed by the facility's quality assurance and performance improvement committee to detect potential patterns or trends and for consideration of further interventions or training opportunities. 1. Resident #76 was admitted to the facility on 5/20/2023. The admission Minimum Data Set (MDS) assessment dated 5/26/2023 indicated Resident #76 was moderately impaired cognitively and required assistance with toileting and bathing. Nursing documentation dated 7/6/2023 at 7:42	F 607	private room and received Psychological Consult by a Licensed Clinician on 5/18/23. On 7/06/23 the Regional Nurse Consultant started reeducating all Department Managers on the entire Abuse policy with additional emphasis on timely reporting, components required for the completion of an investigations, and the immediate steps necessary to ensure resident safety at time of alleged abuse. This education was completed by 7/06/23. On 7/19/23 the Regional Nurse Consultant completed an additional detailed inservice with Facility Administration: Interim Administrator, Interim Director of Nursing, Staff Development Coordinator, and Unit Managers to ensure they understood the reporting requirements for Abuse Allegations Education. This was completed on 7/19/23. 2. On 7/11/23 the Social Services Director conducted abuse interviews and Licensed Nurses completed skin assessments to ensure no signs of abuse were present in the facility. These interviews and assessments were completed on 7/11/23. Additional concerns of abuse were noted and reported to the Department of Health and Human Services on 7/11/23 or prior to this date.	

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F 607	Continued From page 10 a.m. by Nurse #4 stated around 5:00 a.m. Resident #76 reported Nurse Aide (NA) #2 had assaulted her and closed the door when Resident #76 confronted her about not answering her call light. Nurse #4 assessed Resident #76 for injuries and recorded Resident #76 stated she was okay. Nurse #4 recorded she informed NA #2, she would answer Resident #76's call lights and provide care as needed. A review of the initial report alleging employee to resident abuse dated 7/7/2023 stated the facility became aware of the incident on 7/7/2023 at 8:35 a.m. and the local law enforcement agency was notified on 7/7/2023 at 8:35 a.m. The initial report was signed by the interim Director of Nursing, and there was a handwritten notation that the initial report was refaxed to the state agency on 7/7/2023 at 4:45 p.m. In an interview with Resident #76 on 7/10/2023 at 12:05 p.m. she stated she made a police report after NA #2 pushed her back onto the bed, turned off the light and shut the door last week. She stated someone got NA #2 out of the facility, and she had not spoken to anyone in Administration. In a follow up interview with Resident #76 on 7/12/2023 at 8:27 a.m., she stated the incident with NA #2 occurred last at night around 8:00 p.m. to 9:00 p.m. She explained she needed someone to come help her change the adult brief. The NA #2 and her were started fussing to each other, and NA #2 with her fingers extended pushed her right shoulder and pushed her down onto the bed into a sitting position. She stated NA #2 turned off the lights and shut the door. She explained when Nurse #4 entered and assisted her with changing her adult brief, she informed Nurse #4 what had happen between Resident	F 607	3. On 7/7/23, the Regional Nurse and Staff Development coordinator in serviced all Staff (including agency, housekeeping, dietary, and Therapy) on the policy of Abuse and Neglect with emphasis on immediate steps taken to protect the resident, timely reporting to the Abuse Coordinator, Timely reporting to Department of Health and Human Services, Components of thorough investigations, and the importance of treating each resident with dignity and respect. On 7/7/23 all staff started abuse testing to ensure their competency was reached on the facility abuse policy. This was completed on 7/8/23 The Director of Nursing/ designee will ensure that any staff who does not complete the in-service training by 8/2/23, will complete abuse training before being allowed to work. 4. The Regional Nurse Consultant and/or Regional VP of Operations will review all allegations of abuse and neglect for appropriate and timely removal of alleged perpetrator, timely reporting to the Department of Health and Human Services, and review for completion of all abuse investigations weekly times four, then monthly times two month using the Abuse and Neglect Facility Compliance Quality Assurance tool.	

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(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
F 607	Continued From page 11 #76 and NA #2. In an interview with Vice President of Operations #1 and Vice President of Operations #2 on 7/10/2023 at 1:00 p.m., they stated the Administration office was informed of the alleged employee to resident abuse on 7/7/2023 with Resident #76, and an initial report was submitted to the state agency and local law enforcement had been notified. In a phone interview with NA #2 on 7/10/2023 at 8:36 p.m., she stated at the beginning of the 7p.m.-7a.m. shift dinner meal trays were still out in residents' rooms. When entering Resident #76's room, she found Resident #76 naked waist down. She stated she provided Resident #76 perineal care and changed her bed linens. She stated Resident #76 sat on the side of the bed and didn't fall backwards on the bed after linens were changed. She stated after exiting the room Resident #76's call light was on. When asked if she was okay, Resident #76 asked why she came into her room and closed the door. She explained Resident #76 became combative, and she went and got Nurse #4. When they returned to Resident #76's room, she told Nurse #4 I had pushed her, and she had called the police. She stated this incident happened within the first hour of the 7:00 p.m. to 7:00 a.m. shift and Nurse #4 informed her she would answer Resident #76's call light and provided care as needed. In a phone interview with Nurse #4 on 7/11/2023 at 9:58 p.m., she stated at the beginning of the 7:00 p.m. to 7:00 a.m. shift on 7/6/2023, Resident #76 was yelling out, and nurse aides were busy with other residents. She explained when she entered Resident #76's room, Resident #76	F 607	The Facility Nurse Managers/designees will monitor and round halls for any signs of Abuse and Neglect daily for 1 month then weekly times 8, using the Clinical Team Abuse and Neglect Monitoring and Rounding Quality Assurance tool. All Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Sets Coordinator, Health Information Manager, Unit Managers, and the Dietary Manager.	

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asked for other staff member, NA #2 that she had seen walking up and down the hall. Nurse #4 stated she explained to Resident #76 that NA #2 was busy with another resident and she was there to assist her. Nurse #4 stated she assisted Resident #76 in changing her adult brief and provided a gown and blanket to Resident #76. bed linens. Nurse #4 stated Resident #76's door was closed around 5:00 a.m. when she entered Resident #76's room during medication pass, and that was when Resident #76 informed her NA #2 had hit her and pushed Resident #76 onto the bed, turned light off and closed her door to the room. She explained she completed an assessment on Resident #76 with no injury observed. Nurse #4 stated she informed NA #2 to write a statement and not to go back into Resident #76's room. She stated she didn't not see NA #2 in the building the remaining of the shift.

Nurse #4 stated she called could not recall the name of the person she called to report the incident of alleged abuse on 7/7/2023. She stated she called the number in the information book and left a voice message. She explained at the change of shift on 7/7/2023 7:00 a.m. she informed Nurse #6 of Resident #76's allegation of abuse and Nurse #6 called the Staff Development Coordinator (SDC). She explained since the incident, the SDC had provided abuse training with her because Administration did not receive a report of abuse from me on 7/7/2023. She stated the number for the interim Director of Nursing was posted at the nursing station now and stated it was not the number she called on 7/7/2023.

In an interview with Nurse #6 on 7/11/2023 at 1:12 p.m., she stated about 7:30 a.m. on

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7/7/2023 Nurse #4 inform her Resident #76 had alleged during the night shift that NA #2 called the police because NA #2 had hit her. She stated she immediately called the interim Director of Nursing (DON), who returned her call at 7:32 a.m. on 7/7/2023 and went to speak with Resident #76.

In an interview with the Staff Development Coordinator (SDC) on 7/11/2023 at 12:46 p.m., she stated the interim DON called her at 6:50 a.m. on 7/7/2023 to report Resident #76 had alleged NA #2 had hit her. She explained she lived the closest to the facility and reported to the facility and began the abuse protocol for alleged abuse. She stated Nurse #4 working the 7 p.m.- 7 a.m. shift should had been the nurse to notify the interim DON of the incident.

In an interview with the interim Director of Nursing (DON) on 7/11/2023 at 12:13 p.m., she stated she had been acting as interim for the last two weeks and could not recall receiving a phone call before 7:33 a.m. of the morning of 7/7/2023 to report an alleged employee to resident abuse for Resident #76. She explained Nurse #6 notified her of Resident #76's allegation, and she informed the SDC so she could start the abuse protocol until she arrived. The interim DON stated Nurse #4 should had reported the incident upon learning of the alleged abuse at 5:00 a.m. so the facility could send the initial report to the state agency within two hours of learning of an alleged abuse incident. She further explained the initial report was completed incorrectly as the reason for resubmitting the initial report to the state agency at 4:45 p.m. on 7/7/2023. The

In an interview with the Regional Nurse Consultant on 7/12/2023 at 10:06 a.m., she

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stated the interim DON's name and number to contact after the departure of the Administrator from the facility on 7/7/2023 was placed throughout the facility but did not list her as the abuse coordinator. She stated Nurse #4 should had immediately reported the alleged abuse incident to the abuse coordinator so the initial report can be sent to the state agency within two hours. In a follow up interview on 7/13/2023 at 5:47 p.m., she stated contact information for all administration staff was available to the nursing staff, and Nurse #4 should had continued to call up the administrative chain of command if no response was received from leaving a voice mail to report an alleged abuse incident.

In an interview with Vice President of Operations #1 and Vice President (VP) of Operations #2 on 7/13/2023 at 6:00 p.m., VP of Operations #2 stated the facility had a 24-hours care line and an administrative chain of command for Nurse #4 to call to report alleged abuse incidents if notification of the abuse coordinator went to voice mail. He stated the facility was to report the initial report to the state agency within 2 hours of Resident #76 alleging abuse.

2. a. Resident #7 was admitted to the facility on 2/16/2022 and discharged on 7/9/2023.

The quarterly Minimum Data Set (MDS) assessment dated 3/22/2023 indicated Resident #7 was moderately impaired cognitively with inattention and disorganized thinking was continuously present. The MDS also indicated Resident #7 experienced hallucinations and delusions and had displayed physical and verbal behaviors toward others in 1-3 days of the seven-day look back period.

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b. Resident #15 was admitted to the facility on 11/3/2009.

The quarterly Minimum Data Set (MDS) assessment dated 7/6/2023 indicated Resident #15 was moderately impaired cognitively.

Nursing documentation dated 5/17/2023 at 2:41 a.m. by Nurse #5 revealed Resident #7 exhibited aggressive and combative behavior towards her roommate, Resident #15, and NA #4 witnessed Resident #7 walking away from Resident #15 who was lying in the bed. Resident #7 informed Nurse #5 "she slept with my man", and Resident #15 informed Nurse #5, "she hit me on my arm and hand". Nurse #5's assessment of Resident #15 found no injuries and moved Resident #15 to room 509B for her safety.

The facility's "Initial Allegation Report" to the state agency dated 5/17/2023 at 8:45 a.m. written by the Administrator documented staff reported that a resident hit another resident on her arm and hand.

The facility's reported the census on 5/17/2023 was 77 residents.

A review of the documented resident questionnaire for abuse dated 5/17/2023 revealed 19 residents in the facility were interviewed.

There were 15 documented resident skin care assessments reviewed related to the resident-to-resident abuse investigation for 5/17/2023. Resident #7's skin assessment was documented completed on 5/17/2023. The remaining 14 skin assessments were dated prior to the

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resident-to-resident abuse incident on 5/17/2023: 12 residents skin assessment dated 5/15/2023, 1 resident skin assessment dated 5/14/2023 and on 1 resident skin assessment dated 5/10/2023. There was no documented skin assessment for Resident #15, and there were no other skin assessment documents provided by the facility to review.

Review of written statements related to the resident-to-resident abuse incident on 5/17/2023 included one by Nurse #5. Nurse #5's statement dated 5/18/2023 stated at approximately 2:00 a.m. Resident #7 was exhibiting aggression and combative behaviors toward her roommate, Resident #15, while she was lying in bed. She wrote NA #4 heard yelling and screaming and witnessed Resident #7 walking away from Resident #15's bed when entering the room. She wrote Resident #7 was yelling out angrily, "She slept with my man" when she entered the room, and Resident #15 stated, "She hit me on my arm and hand." Resident #15 was assessed with no injury identified and Resident #7 continued to show aggressive behaviors and refusing medications. Resident #15 was moved to room 509-B for safety reasons. There were no written statements from nursing staff, Resident #15 and Resident #7 provided for review.

The timeline for the resident-to-resident abuse incident on 5/17/2023 written by the Administrator on 5/22/2023 stated the resident-to-resident abuse incident between Resident #7 and Resident #15 was reported to the Administrator on 5/17/2023 at 8:45 a.m. The timeline reported Resident #7 was not interviewed due her cognitive and mental status at the time, and Resident #15 stated Resident #7 hit her on her

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hand and arm. The physician, resident representatives and police were notified. The timeline further stated head to toe skin assessments were completed on all other residents with a Brief Interview for Mental Status (BIMS) of 7 or less and interviews with done on residents with BIMS of 8 or greater. There were witnesses agreeing with Resident #15, and the allegation of physical abuse by Resident #7 against Resident #15 was substantiated. The timeline further stated the facility's staff was and would continue to be educated on abuse and neglect and the importance of timely notification for abuse and neglect.

The facility's 5-day Investigation report dated 5/22/2023 by the Administrator indicated the allegation of abuse between Resident #7 and Resident #15 was substantiated.

In an interview with Resident #15 on 7/13/2023 at 1:00 p.m., she stated she didn't know why Resident #7 hit her on 5/17/2023. She said the nursing staff came into the room and stopped Resident #7 from hitting her and she wasn't hurt. She stated she was moved to another room and felt safe at the facility.

In an interview with NA #4 on 7/11/2023 at 6:59 p.m., she stated on 5/17/2023 she heard someone hollering and when she got to Resident #15's room, she observed Resident #7 standing over Resident #15's bed and hitting her with a fist hand. She stated she could not see where she was sitting her and Resident #7 returned to her bed when instructed by the staff. She explained she went to get Nurse #5 when another nurse aide, who she was unable to recall by name, came into the room and moved Resident #15 to

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room 509-B. She recalled it was late in the night when the abuse incident occurred.

In a phone interview with Nurse #5 on 7/11/2023 at 5:42 p.m., she stated on 5/17/2023, Nurse Aide #4 reported Resident #15 was screaming and yelling, and Resident #7 was observed standing over Resident #15. Upon enter Resident #15 and Resident #7 's room, Resident #7 stated Resident #15 had slept with her man. NA #4 stated Resident #7 had hit Resident #15 and when asked, Resident #15 stated, "Yes, on my arm". Nurse #5 stated she assessed Resident #15 and found no redness or bruising to the hand and arm area. She stated for the safety of Resident #15, she moved the resident to room 509B. She explained the resident-to-resident incident occurred after the night medication pass between 11:00 p.m. and 12:00 a.m., and she called the Administrator right after the incident occurred after transferring Resident #15 to another room and to inform the Administrator of the incident.

In a phone interview with the former Administrator on 7/11/2023 at 6:13 p.m., she stated the time on the initial report (5/17/2023 at 8:45 a.m.) was the time she was notified of the resident-to resident abuse between Resident #7 and Resident #15. She stated the nursing staff didn't always report abuse immediately and sometimes she was not notified. She explained an investigation of abuse incidents included interviewing the nursing staff and residents and conducting resident skin assessments or resident interviews based on the BIMS of the resident for all residents. She stated the resident skin assessments dated prior to 5/17/2023 was not right and resident skin assessments should have been conducted after the resident-to resident abuse incident.

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In an interview with Regional Nurse Consultant on 7/12/2023 at 10:26 a.m., she explained that investigations of abuse should include statements from the residents involved, all staff involved, the initial report, the 5-day report, assessments of abuse for all residents (resident skin assessments and interviews). She stated based on the information provided on the resident-to-resident abuse incident on 5/17/2023, a complete investigation was not completed. In another interview on 7/13/2023 at 5:47 p.m., she stated there was no other information to provide for the resident-to-resident investigation between Resident #7 and Resident #15. She stated all residents did not receive a skin assessment or interview.

In an interview with Vice President of Operations #1 and Vice President (VP) of Operations #2 on 7/13/2023 at 6:00 p.m., VP of Operations #1 stated after an allegation of abuse staff and residents involved were interviewed and all residents were to be assessed by an interview or skin assessments.

3. Resident #40 was admitted to the facility on 6/15/23.

Resident #40's admission Minimum Data Set (MDS) assessment dated 6/22/23 indicated severe cognitive impairment.

An interview was conducted with Resident #40 on 7/11/23 at 9:51 AM. She was alert to person, place, time and situation. Resident #40 stated that on 6/24/23 she informed staff held her wrists and caused her bruises when they removed money from her room after a room search was

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completed that she didn't consent to. She stated her wrist was bruised during the altercation.

An interview was conducted with Nurse #7 on 7/11/23 at 2:45 PM who stated on 6/24/23 Resident #40 stated staff forcibly removed money from her room and there was a "struggle". Nurse #7 stated Resident #40 indicated staff were pulling on her and she was shaken up a bit. He stated Resident #40 initially stated staff struck her but when he further questioned Resident #40, she stated she struck herself during the altercation. He did not report this allegation to the Administrator on 6/24/23 because Resident #40 stated she had struck herself.

During a phone interview with Resident #40's family member on 7/11/23 at 4:30 PM she stated she spoke with the Administrator on 6/29/23 about Resident #40's bruises she saw on 6/29/23. She stated she informed the Administrator that Resident #40 stated staff were aggressive and injured her when they removed her money from her room. She stated the Administrator got Nurse #7 to check Resident #40 for bruises.

During an interview with the Administrator on 7/11/23 at 2:15 PM she reported she heard Resident #40 state she was being held down and hit by staff on 6/24/23 while she was on the phone with Nurse #5 as Resident #40's money was being counted following the room search. She recalled on 6/26/23 she spoke with Resident #40 and the resident stated staff had struck her on 6/24/23 and she had a bruise. The Administrator stated she was informed by Nurse #7 on 6/26/23 that when he spoke with Resident #40 on 6/24/23 about the incident her story changed a and she stated she struck herself.

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F 607	Continued From page 21 She stated Resident #40 never mentioned it to her again. The Administrator stated she met with Resident #40's family member on 6/29/23 and the family mentioned Resident #40 stated that she had been abused and had a bruise on her wrist. She stated she initially did not do a report to the State because she was unaware it needed to be reported. She explained when subsequent allegations were made on 6/26/23 by Resident #40 and her family member she had followed up with Nurse #7 who stated she recanted when he spoke with her on 6/24/23. She stated there was no investigation of Resident #40's allegations of abuse. An interview was conducted with Regional Vice President of Operations #1, Regional Vice President of Operations #2, and the Regional Nurse Consultant on 7/11/23 at 4:00 PM who stated they were not aware a report to the State was not made regarding Resident #40's allegations of abuse. Review of an initial report to the State dated 7/11/23 revealed an initial report was made related to Resident #40's allegation of abuse that occurred on 6/24/23.	F 607		
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, observations and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1	F 641	1. On 7/13/23 the Regional Nurse Consultant provided Surveyor with an assessment/observation that deemed the	8/7/23

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of 1 resident whose MDS was reviewed for the use of restraints (Resident #61).

Findings included:

Resident #61 was admitted to the facility on 7/13/2021, and diagnoses included dementia and use of gastrostomy tube.

Nursing documentation dated 7/24/2022 recorded Resident #61's representative provided consent for the use of an abdominal binder and was educated on the use of restraints and side effects from the use of the abdominal binder.

Physician orders dated 12/1/2022 included an enteral feeding at 60 milliliters an hour from 6 p.m. to 6 a.m. twice a day, and phsyican orders dated 3/23/2023 included abdominal binder release and assess skin every two hours. If any change of condition, notify physician.

Surgical progress notes for percutaneous endoscopic gastrostomy (PEG) placement date 3/21/2023 due to self-removal of gastrostomy tube stated it was essential that the abdominal binder remain in place.

An observation assessment dated 5/23/2023 indicated implementation use of an abdominal binder, a restrictive device, for Resident #61 as an enabler and consent for use from Resident #61's representative.

The June 2023 Medication Administration Record recorded the abdominal binder was released every 2 hours and skin was assessed daily.

The quarterly MDS dated 6/28/2023 indicated abdominal binder an enabler, dated 5/23/23. This abdominal binder was also care planned accordingly.

On 7/31/23 for resident #61 the MDS Coordinator has modified the MDS assessment with an ARD of 6/28/23 to include coding of restraint. On 7/17/23 Physician gave an order to discontinue the abdominal binder for resident #61. No adverse effects were noted.

2. On 7/31/23 the Clinical Reimbursement Specialist (CRS) and/or Signature Care Consultant (SCC) reviewed all residents for any medical order for a device that could be considered a restraint. No other modifications were needed.

3. On 8/2/23, the Home Office Clinical Reimbursement Specialist (CRS) educated MDS Coordinator on the accuracy coding of MDS Assessment for section P physical restraints. The training is provided to MDS Coordinators per RAI manual.

4. The CRS will review up to 5 MDS assessments with ARDs after 8/9/23 for 4 weeks for those residents with medical orders of devices that could be considered as a restraint. After the first 4 weeks, 5 assessments will be reviewed monthly for 2 months; 5 assessments will be reviewed quarterly for 2 quarters. QA Reports will be presented to the weekly QA committee by the MDS Coordinator to

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F 641	Continued From page 23 Resident #61 was severely cognitively impaired with no limitations in upper body movements. The MDS also indicated Resident #61 required total assistance with eating and received greater than 51% of dietary calories and greater than 501 milliliters of fluids through tube feedings. The MDS was not marked for the use of a restraint. On 7/12/2023 at 8:18 a.m., when Nurse Aide (NA) #1 uncovered Resident #61's abdominal (stomach) area, a white abdominal binder was observed wrapped front and back and closed by Velcro (hoop and loop fastener used to adhere and secure items) around the abdominal area. NA #1 stated the abdominal binder was used to prevent Resident #61 from pulling the gastrostomy tube. In an interview with the MDS Nurse #2 on 7/13/2023 at 4:54 p.m., she stated the abdominal binder was being used for medical reasons. She said it was a medical device, not a restraint, used to keep Resident #61 from self-pulling out the gastrostomy tube ordered by the physician. She stated the use of the abdominal binder had never been coded as a restraint in the MDS assessment. In an interview with the Regional Nurse Consultant on 7/13/2023 at 5:47 p.m., she stated an abdominal binder was a restraint, and when Resident #61 was assessed for the use of the abdominal binder, it was determined to be an enabler and not a restraint. In an interview with Regional Vice President (VP) #1 and Regional Vice President #2 on 7/13/2023 at 6:14 p.m., VP #1 stated the abdominal binder was not a restraint if Resident #61 could remove	F 641	ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly and Monthly QA Meeting. The weekly as well as the Monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Staff Development Coordinator, Social Service Director, Health information Manager, Maintenance Director, and the Dietary Manager. Findings will be presented to Quality Assurance Committee. The plan will be revised as warranted.	

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F 641	Continued From page 24 the abdominal binder, and he wasn't aware a medical device used to prevent Resident #61 from pulling the gastrostomy tube was a restraint. Regional Vice President #2 stated the MDS assessment should be coded accurately, and he did not think the abdominal binder was a restraint.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow a physician's order to call the physician for a blood glucose reading greater than 550 for two incidents of a "high" blood glucose reading on 6/25/2023 and to obtain physician orders to administration insulin coverage for the "high " glucose readings for 1 of 2 residents reviewed for the use of insulin. (Resident #82) Findings included: Resident #82 was admitted to the facility on 6/20/2023, and diagnoses included Diabetes Mellitus. There was a physician order dated 6/20/2023 to check Resident #82's blood glucose four times a day before meals and at bedtime and to administer Tresiba 100 units per milliliter (mL) 6 units once a day at night. On 6/21/2023,	F 658	1. Resident #82 is no longer in the facility. On 7/28/23, the Regional Nurse Consultant reeducated Nurse #5, Nurse #6, and Nurse #7 on the importance of notifying the physician and following physician orders as directed by the Sliding Scale Insulin. 2. On 7/28/23, the Director of Nursing and Regional Nurse Consultant identified all residents currently on sliding scale insulin and completed a 100% audit of the last 30 days of blood sugar results and dosages of insulin administered. All concerns related to diabetes management were communicated to the physician on 7/31/2023 and all new orders were received and implemented by 8/1/23. 3. On 7/28/23, the Regional Nurse Consultant in serviced all licensed nurses on Diabetes Management and the	8/7/23

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F 658	Continued From page 25 Humalog sliding scale insulin 100 units per milliliter was ordered as the following: * Blood glucose reading less than 60; call the physician. * Blood glucose reading between 200-250; give 3 units Humalog insulin. * Blood glucose reading between 251-300; give 5units Humalog insulin. * Blood glucose reading between 301-350; give 7 units Humalog insulin. * Blood glucose reading between 351-400; give 10 units Humalog insulin. * Blood glucose reading between 401-500; give 14units Humalog insulin. * Blood glucose reading between 501-550; give 16 units Humalog insulin. * Blood glucose reading greater than 550; call physician. A review of the June 2023 Medication Administration Record (MAR) for Resident #82 recorded the blood glucose reading as "high" on 6/25/2023 at 12:00 p.m., 4:00 p.m. and 8: 00 p.m. Under comments on the June 2023 MAR, Nurse #7 documented late on 6/25/2023 at 6:31 p.m. Resident #82 was given 8 units of Humalog insulin at 12:00 p.m. and 4:00 p.m. Nurse #5 documented on 6/25/2023 at 8:00 p.m., Resident #82 refused 16 units of Humalog insulin and only wanted 6 units Humalog insulin. Resident #82's next blood glucose reading recorded was 176 at 12:00 p.m. on 6/26/2023. There was no nursing documentation reporting the physician was notified of the "high" blood glucose readings on 6/25/2023 at 12:00 p.m., 4:00 p.m. and 8:00 p.m. found in Resident #82's medical record.	F 658	importance of following Sliding Scale insulin orders. This training included: " Medication Administration and follow up related to Insulin. Importance of following physician orders and ensuring we notify MD/RP related to residents□ changes in condition emphasis on HIGH and LOW blood sugars. The Director of Nursing/designee will ensure that any identified staff (to include Agency) who do not complete the in-service training by 8/2/23 will not be allowed to work until the training is completed. 4. The Director of Nursing/designee will monitor the residents Sliding Scale Insulin to ensure Physician orders are followed with emphasis of significant High or Lows to ensure concerns will be communicated to the physician. 1 on 1 education or disciplinary actions will be completed immediately when warranted. All Sliding scale insulins will be reviewed M-F in Clinical Whiteboard Meeting. This review will be documented on the Sliding Scale insulin QA monitoring tool M-F times 2 weeks. Then weekly for 4 weeks and then monthly for 2 months using a Sliding Scale Insulin QA monitoring tool. QA Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The	

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F 658	Continued From page 26 Nurse #7 created a physician telephone order for Humalog 100units per milliliter 8 units subcutaneous immediately on 6/25/2023 at 6:07 p.m. There were no other new physician orders for insulin coverage found on Resident #82's chart for 6/25/2023. The admission Minimum Data Set (MDS) assessment dated 6/27/2023 indicated Resident #82 was cognitively intact and had received seven injections of insulin in the seven-day look back period. Resident #82's care plan dated 7/1/2023 included a focus for the risk of unstable blood glucose. Interventions included monitoring the blood glucose as physician ordered, providing meals as ordered and encouraging diet compliance and notifying the physician with significant changes in sign and symptoms of hyperglycemia. In a phone interview with Nurse #7 on 7/13/2023 at 10:27 a.m., she stated she recalled Resident #82 would refuse his insulin and wanted to tell the nursing staff the amount of insulin to administer. She stated she did not recall Resident #82's blood glucose reading being "high". She explained when a blood glucose level read "high", the physician was called for orders, and new orders were placed in the computer. She said documentation of a "high" blood glucose reading and treatment, if not documented on the MAR, would be documented in the nursing notes or on a situation background assessment recommendation (SBAR) form. In a phone interview with Nurse #5 on 7/13/2023 at 12:30 p.m., she stated when Resident #82's blood glucose readings were "high" she was to	F 658	weekly as well as the Monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Staff Development Coordinator, Social Service Director, Health Information□s Manager, Maintenance Director, and the Dietary Manager.	

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F 658	Continued From page 27	F 658		

call the physician. She explained when blood glucose readings read "high" she would give the maximum dose of insulin on the sliding scale while waiting for the physician to call. She stated when she worked the 7:00 p.m. to 7:00 a.m. (night shift), it was difficult to reach the physician. When calling the physician, a nurse answered and asked multiple questions, or you left a message with no return call. She stated on 6/25/2023 she did not call the physician and used her own judgement to administer Resident #82 insulin for the "high" blood glucose reading. She said Resident #82 refused Humalog 16 units, the highest amount ordered on the Humalog sliding scale, and was given Humalog 6 units as resident requested.

In a phone interview with Physician #1 on 7/13/2023 at 2:32 p.m., she stated she was unable to recall receiving a call from Nurse #7 and Nurse #5 on 6/25/2023 due to Resident #82's blood glucose reading being "high". She explained there was a physician on-call every night, and there was an advice nurse that gathered information before calling the physician on-call. She stated based on the Humalog sliding scale order, the nursing staff was to call the physician for specific new orders for blood glucose readings greater than the Humalog sliding scale.

In an interview with the interim Director of Nursing and Regional Nurse Consultant on 7/13/2023 at 5:30 p.m., the Regional Nurse Consultant stated Nurse #7 and Nurse #5 should had called the physician for each "high" blood glucose reading as ordered on the Humalog sliding scale order. She stated medications were to be administered as ordered by a physician, and new physician

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F 658	Continued From page 28 orders were to entered into the Resident #82's electronic medical record.	F 658		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a medication storage refrigerator within the recommended temperature range and failed to discard outdated ophthalmic solution bottles for 2 of 3 medication storage areas reviewed (#1	F 761	1. On 7/11/23 the Interim Director of nursing removed medications from the refrigerator and outdated eye drops from Med Cart #2. All medication removed were also reorder and replaced as need by the Interim Director of nursing. No	8/7/23

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F 761	Continued From page 29 Medication Room and Medication Cart #2). Findings included: 1. An observation of the medication storage refrigerator located in the #1 Medication Room was made on 7/11/23 at 3:00 PM with Nurse #1. The refrigerator thermometer was observed at 32 degrees Fahrenheit (°F). Nurse #1 viewed the refrigerator thermometer and indicated it appeared to read between 32°F and 34 °F. The July 2023 temperature monitoring log for the medication storage refrigerator had been noted daily. Temperatures recorded included: 7/4/23 was 34 °F, 7/5/23 was 32 °F, 7/6/23 was 32 °F, 7/8/23 was 34 °F, 7/9/23 was 34 °F, and 7/10/23 was 30 °F. The instructions on the monitoring log indicated "Temperature of refrigerator must be between 36-41 degree F, Freezer must be at or below freezing, If not contact maintenance immediately! Only maintenance is authorized to adjust refrigerator settings!" The refrigerator contained: 15- Insulin glargine pens 100 units. The package instructions noted "store 36-46 degrees, avoid freezing, discard if frozen." 8- Insulin glargine pens 100 units. The package instructions noted "unopened [insulin glargine] devices should be stored in a refrigerator 36-46 degrees. Do not freeze, discard if frozen." 1- Insulin aspart 100 unit vial with package instructions to store between 36-46 degrees.	F 761	negative outcomes were revealed due to outdated medication nor due to refrigerator temperature being too low. 2. All residents have the potential to be affected. An audit was conducted on 7/18/23 by Licensed Nurses to ensure no other expired medications or refrigerator temperatures were outside of the desired temperature. No additional concerns noted. 3. The DON/designee will educate all Licensed Nursing staff (including agency) on the appropriate Storage of Medications/Biologicals. This education was completed on 8/2/23. The Director of Nursing/designee will ensure that any staff (including agency) who does not complete the in-service training by 8/2/23 will not be allowed to work until the training is completed. 4. The DON/Designee will audit all three medication carts and two medication room refrigerators weekly x 1 month, then 5 residents weekly x 1 month, then 5 residents monthly x 1 month to ensure safe storage of medications and biologicals. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, Health Information Management, and the Dietary Manager.	

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F 761	Continued From page 30 1- Insulin detemir 100 unit vial with package instructions store 36-46 degrees, do not freeze. 27- Dronabinol 5 mg capsules. No storage instructions were observed on the package. An interview with Nurse #1 was conducted on 7/11/23 at 3:09 PM. She explained she was unsure who checked the refrigerator temperature daily, but the temps should be within range or reported to maintenance. 2. An observation of Medication Cart #2 was made on 7/11/23 at 3:37 PM with Nurse #2. Two bottles of latanoprost ophthalmic solution were noted as opened on 4/11/23. Package instructions indicate to discard 6 weeks after opening. An interview with Nurse #2 was conducted on 7/11/23 at 3:45 PM. She explained the evening nurse administered this medication and she had not noticed the dates on the bottles. An interview with Medication Aide #1 was conducted on 7/11/23 at 3:54 PM. She stated she occasionally stayed over to help the evening shift administer medications. She explained she had checked the expiration date of the eye drops but did not realize they should be discarded 6 weeks after opening. An interview was conducted with the Director of Nursing (DON) on 7/11/23 at 5:19 PM. The DON indicated the nurse who checked the medication refrigerator should have contacted maintenance when the out of range temperatures had been	F 761	All findings will be reported to the QA committee monthly and the QA committee will determine what further monitoring is required.	

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F 761	Continued From page 31 discovered. The DON explained the outdated eye drops had an opened on date and the discard by date should have also been noted.	F 761		
F 812 SS=D	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. §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 expired chocolate milk cartons from the walk-in refrigerator. On 7/10/2023, expired chocolate milk cartons dated 7/9/2023 were observed on 2 of 2 resident's breakfast meal trays (Resident #56 and Resident #22) when breakfast meal trays were returned to the kitchen. This practice had the potential to cause food borne illness. Findings included:	F 812	1. After breakfast on the 10th of July, the District Manager and Dietary Manager checked and discarded 6 cartons of chocolate milk that were in the walk in cooler. No adverse reactions were noted by residents that received chocolate milk on the 10th of July. " On 7.10.2023 all expired milk were immediately removed and discarded by the	8/7/23

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F 812	Continued From page 32 On 7/10/2023 at 9:52 a.m. during an observation of the walk-in refrigerator in the kitchen with the Dietary Manager and Regional Dietary Manager, six chocolate milk cartons with an expiration date of 7/9/2023 were observed in the milk crate in the walk-in refrigerator. The Dietary Manager and Regional Dietary Manager were observed discarding the six cartons of expired chocolate milk into the trash. On 7/10/2023 at 9:52 a.m., the Regional Dietary Manager stated she was watched the breakfast serving line the morning of 7/10/2023, and none of the residents received chocolate milk at breakfast. The Dietary Manager stated the expiration date on the chocolate milk cartons was to be checked every morning before going out on the meal trays. On 7/10/2023 at 10:13 a.m. two chocolate milk cartons with expiration date of 7/9/2023 were observed on Resident #56's and Resident #22's breakfast tray on the meal cart returned to the kitchen. Resident #56's chocolate milk was observed opened and half emptied. Resident #22's chocolate milk was observed sealed and returned to the kitchen unopened. On 7/10/2023 at 10:13 a.m., the Regional Dietary Manager stated she did not think any residents got chocolate milk on the serving line that morning. On 7/10/2023 at 2:32 p.m. in an interview with Resident #56, she stated the chocolate milk she drank at breakfast on 7/10/2023 tasted good. On 7/10/2023 at 2:50 p.m. in an interview with	F 812	Regional Dietary Manager. " On 7.10.023 an audit of the refrigerator and freezer were assessed for unlabeled, undated, expired food items. 2. Dietary Staff to audit milk daily for expiration dates prior to meal service daily and document findings. First Shift to do breakfast and lunch, Second Shift to do dinner. Audits began on the 11th of July 2023. 3. Dietary Staff (including Dietary Manager) were in-serviced on the 10th of July on the following subjects: Label and Dating, Product Rotation (FIFO), and discarding of products that are out of date. This also included an in-service on an audit tool for checking milk prior to each meal service and discarding of milk that expires - District Manager (noted as regional in 2567 - in-serviced by the Director of Clinical Operations) " Dietary Staff to audit milk daily for expiration dates prior to meal service daily and document findings. First Shift to do breakfast and lunch, Second Shift to do dinner. Audits began on the 11th of July 2023 " Dietary Staff (Second Shift) to discard any milk daily that expires that day after dinner service " Dietary Manager to validate audit for	

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F 812	Continued From page 33 Nurse Aide #3, she stated she delivered Resident #56 her breakfast tray on 7/10/2023 and helped set up the breakfast tray by opening the chocolate milk carton. She stated she did not look at the expiration date on the chocolate milk carton. On 7/12/2023 at 12:10 p.m. in an interview with Dietary Aide #1, she explained she was not assigned the beverages on the serving line on 7/10/2023. She stated expiration dates on milk products were to be checked before using and placing on the meal trays. On 7/13/2023 at 6:17 p.m. in an interview with Regional Vice President #1, he stated always check expirations on milk products before use and discard the milk item if expired.	F 812	completion and accuracy on days/meals that they are in the facility " District Manager to validate audit for completion and accuracy on days/meals that they are in the facility 4. The Dietary Manager/designee will be responsible for auditing the refrigerators in the kitchen and night pantry areas 3 times a week for 4 weeks, and then monthly for 3 months. Any issues identified will be immediately addressed, 1:1 re-education completed, with disciplinary action completed as determined by the Dietary Manager or Administrator. The reviews of the refrigerator QA audits will be forwarded to the Administrator/designee for review. The QA audit reviews will be reviewed by the Quality Assurance Performance Improvement Committee monthly for three months, and then quarterly for three quarters. QA Audit Reports will be presented to the weekly QA committee by the Dietary Manager to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly and Monthly QA Meeting. The weekly as well as the Monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Staff Development Coordinator, Social Service	

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	345365	A. BUILDING _____ B. WING _____	C 07/13/2023

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SIGNATURE HEALTHCARE OF KINSTON	907 CUNNINGHAM ROAD KINSTON, NC 28501

(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
F 812	Continued From page 34	F 812	Director, Health information Manager, Maintenance Director, and the Dietary Manager. Any further action required will be as determined by the QAPI committee.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		8/7/23

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F 867	Continued From page 35	F 867		

development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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F 867	Continued From page 37 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint investigation survey of 5/24/22. The deficiency is in the area of food procurement, storage and preparation (F812). The continued failure during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F812: Based on observations and staff interviews, the facility failed to discard expired chocolate milk cartons from the walk-in refrigerator. On 7/10/2023, expired chocolate milk cartons dated 7/9/2023 were observed on 2 of 2 resident's breakfast meal trays (Resident #56 and Resident #22) when breakfast meal trays were returned to the kitchen. This practice had the potential to cause food borne illness. During the recertification and complaint investigation survey of 5/24/22 the facility was cited at F812 for failing to label and date left over food items and discard expired food items available for use in 2 of 2 kitchen refrigerators.	F 867	1. Signature Home Office Clinical Staff assisted with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). 2. All residents have the potential to be affected. 3. Signature Home Office Operational Support educated members of the QAPI Committee this education was completed by Regional VP of Operations regarding the QAPI process. Quality Assessment and Assurance Committee (QAPI) meeting held on 8/2/23, to review the facility Plan of Correction (POC) and to establish a QAPI subcommittee that will meet weekly for (4) weeks then monthly until substantial compliance, to monitor the implementation of the POC, including the education component and the ongoing audit component, they are to evaluate the effectiveness of the POC if necessary provide additional education and request additional audits and report to the facility QAPI Committee no less than quarterly. This subcommittee will consist of the Administrator, Director of Nursing, Social Service, and Signature Home Office Support, (i.e. Regional Nurse Consultant and/or Regional VP of Operations.)	

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F 867	Continued From page 38 Attempts to contact the Administrator on 7/13/23 by phone were not successful. The Director of Nursing was also unavailable for an interview during the survey. An interview with the Regional Vice President was conducted on 7/13/23 at 3:40 PM. He stated the Administrator was not answering her phone so he was unsure of the reason for the repeat deficiency.	F 867	4. This subcommittee will report on the actions of the subcommittee to the facility QAPI committee and the Chief Nursing Officer (CNO) of Signature Health CARE.	