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	345143	A. BUILDING _____ B. WING _____	C 08/02/2023

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SILER CITY CENTER	900 W DOLPHIN STREET SILER CITY, NC 27344

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E 000	Initial Comments An unannounced recertification, complaint investigation and follow-up survey was conducted on 7/16/23 through 7/21/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3ZOL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 07/16/23 through 07/21/23. A surveyor returned to the facility from 7/31/23 through 8/1/23 to reinvestigate a complaint allegation. The extended survey was conducted on 8/2/23. Therefore, the exit date was changed to 08/02/23. Event ID# #XOL11. The following intakes were investigated NC00204618, NC00197707, NC00191213, NC00190664, and NC00190656. 2 of the 12 complaint allegations resulted in deficiency. Intake NC00204618 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J). The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 07/12/23 and was removed on 7/20/23. An extended survey was conducted.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		8/22/23

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

Electronically Signed | 08/16/2023

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F 584	Continued From page 1	F 584		

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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F 584	Continued From page 2 Based on observations and staff interviews, the facility failed to 1) replace 2 bed side commodes with visible rust on the legs and frame for 2 of 6 resident bathrooms (room 104 and 106) and 2) failed to repair or replace broken Packaged Terminal Air Conditioner (PTAC) air filters for 1 out of 12 resident rooms (room 215) reviewed for comfortable, clean, and homelike environment. The findings included: 1) On 07/16/23 from 11:22 AM through 11:41 AM and on 07/17/23 from 10:42 AM through 10:51 AM the following were observed: - Room 104 ' s bathroom had a bedside commode over the toilet. All four legs and the metal frame of the bedside commode had visible rough texture of rust located on the metal surface. Small pieces of light colored rust and paint crumbled off when touched. The room was occupied with continent residents that utilize the bedside commode. The surface was not smooth and not cleanable. - Room 106 ' s bathroom had a bedside commode over the toilet. All four legs and the metal frame of the bedside commode had visible rough texture of rust located on the metal surface. Small pieces of light colored rust and paint crumbled off when touched. The room was occupied with continent residents that utilize the bedside commode. The surface was not smooth and not cleanable. An interview and observation were conducted with the Director of Nursing (DON) on 07/17/23 at 4:01 PM. She confirmed that the bed side commodes in rooms 104 and 106 had rust on the	F 584	F584 Safe and Homelike Environment 1) Residents 104 and 106's bedside commodes were replaced on 7/17/23. Room 215's PTAC air filters (2) were replaced on 7/18/23. 2) All residents have the potential to be affected. The Maintenance Director, Maintenance Assistant, Housekeeping Supervisor or Designee(s), on 7/24/23, completed a 100% audit of all bedside commodes and PTAC units. Any identified concerns were corrected. 3) Administrator, Nurse Practice Educator, Maintenance Director or Designee(s) provided education for all staff regarding how to report and/or complete a maintenance/environmental request for correction. 4) Administrator, Maintenance Director, or Department Leader(s), to audit at least 10 resident rooms per week for the next 4 weeks, and then randomly thereafter to ensure that resident rooms are a comfortable, clean and homelike environment. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. The Administrator is responsible for this plan. 5) Date of compliance 8/22/23	

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metal frames and they both needed to be replaced. The DON indicated that she had not been notified by staff that the bed side commodes needed to be replaced. She then went to the storage room between 300 and 400 halls and located 2 bedside commodes that were ready for use and there was no visible rust. The 2 bedside commodes in rooms 104 and 106 were replaced. The two bedside commodes with rust were disposed of.

2) On 07/16/23 from 11:52 AM through 11:58 AM and on 07/17/23 from 10:59 AM through 11:05 AM the following was observed:

- Room 215 PTAC air filters (2) were observed not fully inserted with visible breaks on both sides approximately 3 inches down from the top of the filter frames. The filter screen was incased by the frame. Both filters were folded over at the break and hanging at the top of the PTAC unit. When the Maintenance Director attempted to remove the filters, the broken areas prevented the filters from being inserted past the breaks and were getting caught on the plastic frame making it difficult to remove. The hard plastic frame was exposed. The room was occupied and the PTAC was running at the time of the observation.

An interview and observation were conducted with the Maintenance Director on 07/18/23 at 01:16 PM. The Maintenance Director confirmed the top of 2 filters were hanging down from the front of the PTAC unit. He indicated he was unaware the 2 PTAC filters were broken. He stated housekeeping cleans the filters during their daily rounds and if they find anything broken or damaged, they report the issue to the nurse or to him. He stated it had not been reported to him the

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F 584	Continued From page 4 filters were broken. He removed the broken filters and replaced them. The filters had a thin layer of light gray dust present. An interview was conducted with the District Housekeeping Manager on 07/18/23 at 1:25 PM. He indicated housekeeping should have reported the broken PTAC filter when it was first observed. An interview and observation were conducted with Housekeeper #2 on 07/18/23 at 1:32 PM. She confirmed she was the assigned housekeeper for the 200 hall up until today. She stated she did see the broken PTAC filters when she cleaned them, but she did not think to report it to nursing or to maintenance. She also stated if she comes across anything broken or damaged, she knows the process to report it. An interview was conducted with the Maintenance Director on 07/20/23 at 10:15 AM. He stated he makes rounds monthly to check the PTAC units and the last round included a deep cleaning of the PTAC units. on May 3, 2023. He indicated the filters on the PTAC unit in room 215 were not damaged/broken at that time. An interview was conducted with the Administrator on 07/20/23 at 11:36 AM. He stated he would expect the PTACs and filters to be repaired of any damages.	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		8/22/23

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F 600	Continued From page 5 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, police reports, resident, staff, and psychotherapist interviews, the facility failed to protect moderately cognitively impaired residents (Resident #135 and Resident #49) right to be free from sexual abuse from a cognitively intact resident (Resident #122). During the shift from 7/11/23 at 11:00 P.M. to 7/12/23 at 7:00 A.M., Resident #122 entered Resident #135's room, while he was sleeping, lifted Resident #135's blanket and reached his hand into Resident #135's brief, and then stimulated Resident #135's penis. Resident #135 reported the sexual abuse to Nurse Aide (NA) #1 on 7/12/23 at approximately 4:00 A.M. Resident #135 explained Resident #122 had not been invited into his room and the physical touch was not consensual. Resident #135 reported the incident "hurt me mentally" and "he made me sick." On the evening of 7/11/23 at approximately 11:00 P.M, Resident #49 was lying in bed watching television when Resident #122 entered Resident #49's room and manipulated Resident #49's penis through a blanket. Resident #49 reported this encounter was not consensual. This was for 2 of 3 residents reviewed for abuse.	F 600	F 600 Abuse 1) The Social Services Director interviewed resident # 135 the morning of 7/12/23 to ensure his feeling of safety and the resident reported that he felt safe. Resident # 135 was seen by Psych Services on July 13, 2023 with no additional concerns noted. Social Services met with Resident # 49 to ensure his feeling of safety, the resident reports that he feels safe in the center. Resident # 49 was also referred to psych services for follow up but refused to be seen. 2) All alert and oriented residents with BIMs score greater than 11, to include male and female residents were interviewed by Social Services to determine if any other residents had been involved in a resident to resident event with inappropriate touching on 7/12/23. Social Services educated residents on Resident Rights to be Free from Abuse on 7/19/23. All residents received a skin	

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F 600	Continued From page 6 Immediate Jeopardy began on 7/12/23 when Resident #122 entered Resident #135's room and inappropriately touched Resident #135's genitals without consent. Immediate Jeopardy was removed on 7/20/23 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential of minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Example #2, for Resident #49, was cited at a lower scope and severity of a level "D". The findings included: Resident #135 was admitted to the facility on 2/13/23 with diagnoses that included hemiparesis (mild or partial weakness or loss of strength) following a stroke and generalized muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 5/30/23, showed Resident #135 was moderately cognitively impaired. Resident #135 had physical impairment on one side of his upper body and one side of his lower body. Resident #122 was admitted to the facility on 6/13/23 with diagnoses that included Parkinsons' disease, cognitive communication deficit, and spinal stenosis lumbar region with neurogenic claudication (narrowing of the space around your lower spine, which can compress the blood vessels). The admission MDS assessment dated 6/20/23, showed Resident #122 was cognitively intact. No	F 600	check by licensed nurses/Assistant Director of Nursing on 7/12/23 and validated by the Director of Nursing on 7/12/23. Senior Administrator reviewed the center grievance log on 7/13/23 for any abuse or negative resident interaction concerns for the last 30 days with no negative findings. 3) Education provided to staff (Full Time, Part Time and Agency staff in all disciplines Nursing, Therapy, Housekeeping, Dietary, Laundry, Activities and Administrative Staff) on Abuse Policy and Resident to Resident events on 7/12/23 with no staff working prior to education provided by the Director of Nursing/designee. This education included the types of abuse (Physical, Sexual, Emotional, Neglect and Financial) Education detailed how to report, who to report to, and prevention of abuse. Training detailed what is considered Sexual Abuse; ie: unwanted sexual contact and non contact such as sexual harrassment. Education included that staff should immediately protect the resident when abuse is identified and that anyone can be a perpetrator of abuse. Newly hired and contracted staff will also receive abuse training upon hire by the Assistant Director of Nursing/designee. 4) Social Services will interview 5 staff members per week for six weeks to validate knowledge of abuse reporting, resident altercations and abuse policy. The Administrator will review grievances and risk events 5 X week for six weeks to	

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F 600	Continued From page 7 wandering or physical/verbal behaviors were noted. Review of the facility's initial report dated 7/12/23 read on 7/12/123 at 4:00 A.M. Resident #135 reported another male resident (Resident #122) went into his room and touched him inappropriately. There were no injuries noted. A skin assessment for Resident #135, completed by Nurse #1, on 7/12/23 showed Resident #135 was assessed and showed no signs or symptoms of an injury. Resident #135's skin was intact. There was no redness or bruised areas observed. Review of facility records showed a form titled "Continuous 1:1 Supervision" with Resident #122's name handwritten at the top of the form. The form showed Resident #122 had 1:1 supervision with a start date/ time of 7/12/23 at 4:30 A.M. and an end date/time of 7/14/23 at 3:00 P.M., when Resident #122 was discharged to the community. Review of a police report completed by Police Officer #1, dated 7/12/23 at 5:15 A.M. showed a narrative section that read Resident #135 stated "he woke up during the night to readjust his blanket and noticed that (Resident #122) was at the foot of the bed. He noticed that (Resident #122) had his hand under the blanket and in his briefs touching his penis in a rubbing up and down motion. (Resident #122) asked (Resident #135) if he liked it and he stated, 'S ..., no.' He stated (Resident #122) left the room because the nurses would be checking rooms soon. (Resident #135) had encountered (Resident #122) the day before yesterday, 7/10/23. They were in	F 600	validate that any allegation of neglect/abuse is reported and investigated timely. Social Services will interview 5 residents per week with a BIMs of 11 or greater for six weeks to inquire if they have felt abused, experienced a negative resident to resident interaction or have witnessed or suspected abuse. The Director of Nursing or designee will audit 10 random skin checks for signs and symptoms of abuse weekly for six weeks. Results of all these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. The Administrator will be responsible for this plan. 5) Date of compliance 8/22/23	

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(Resident #135's) room watching TV together and (Resident #122) began to rub on (Resident #135's) leg. He told (Resident #122) to stop. We spoke with (Resident #122) again and he said that he did not inappropriately touch (Resident #135). He did admit to going to his room in the night to watch TV and he readjusted (Resident #135's) blanket." The police report showed Resident #135 did not press charges, but Resident #135 wanted Resident #122 to stay out of his room.

Review of Resident #135's medical record showed a psychotherapist progress note dated 7/13/23 that read in part "Patient reports depression and being a 'victim' of inappropriate sexual behavior from another male resident. Patient processes event stating it 'hurt me mentally. . . he made me sick'."

Review of the facility's 5-day working report dated 7/18/23 showed Resident #135 was awakened by Resident #122 rubbing his private area. Resident #135 reported he knew Resident #122 from therapy sessions. The report read Resident #135 told Resident #122 to leave his room before the nurses came to check on him. Resident #122 left Resident #135's room. During the investigation for the incident dated 7/12/23, Resident #135 reported to staff, prior to this incident over the weekend, Resident #122 had entered Resident #135's room to watch television with him. While Resident #122 was in his room, Resident #135 observed Resident #122 with his hands inside of his own pants. Resident #135 did not say anything to Resident #122 or report this incident to staff prior to 7/12/23.

Review of Resident #135's medical record

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showed a psychotherapist progress note dated 7/20/23 that read in part "Patient reports 'a little' depression this past week. Patient continues to process inappropriate sexual behavior towards him and states 'I didn't do anything to provoke that'."

An interview was conducted on 7/31/23 at 2:38 P.M. with Resident #135. During the shift from 7/11/23 11:00 P.M. to 7/12/23 7:00 A.M., Resident #135 stated he was awakened from sleep by someone moving his brief and his first thought was the nurse aide was checking to see if he had soiled his brief. Resident #135 explained as he became more alert, he realized someone's hand was moving in an up and down motion on his penis. Resident #135 stated it was at this time he realized it was not the nurse aide because the nurse aid had never touched him in that manner. Resident #135 stated Resident #122 had parked his wheelchair against the wall at the foot of his bed, with the wheelchair facing the bed. Resident #135 was standing with his feet on the floor, leaning over the footrest of bed, and had his upper body under Resident #135's blanket. Resident #122 had Resident #135's penis in his hand and was moving it up and down. Resident #135 stated "I felt wet around the places I'm not normally wet and I thought maybe he had blown me off. I didn't want to think about it". He stated Resident #122 asked him if it felt good and he replied "No". During the interview, Resident #135 indicated he told Resident #122 he had to leave his room because the nursing staff would be coming into his room any minute to check on him. When he told Resident #122 this, Resident #122 left his room. Resident #135 was unsure how much time passed from when Resident #122 left his room and the nurse aide entered during a one

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of her routine rounds. Resident #135 stated when the nurse aide entered his room, he told her Resident #122 had touched him inappropriately. Resident #135 indicated NA #1, Nurse #2, and Nurse #1 all entered his room and asked him questions about the incident. During the interview, Resident #135 explained the staff told him the police had been notified. Resident #135 stated he told the police he did not want to press charges because "I didn't want to tarnish my name with this incident." Resident #135 stated staff asked him had Resident #122 previously entered his room uninvited and Resident #135 stated yes. The night before Resident #122 entered his room to watch television and rubbed him on his leg. Resident #135 indicated he did not think much about it until Resident #135 moved his blanket down from his bare chest to scratch a bump and Resident #122 commented he had "some pretty hair on my chest and he asked if he could touch it". Resident #135 responded "no", and Resident #122 immediately left Resident #135's room. During the interview, Resident #135 indicated he felt safe in the facility after the incident when he told staff he did not want Resident #122 in his room again. Resident #122 had staff constantly watching him and he never returned to Resident #135's room.

At the time of the investigation, Resident #122 no longer resided in the facility and was unable to be interviewed.

A telephone interview was conducted on 7/31/23 at 2:06 P.M. with Nurse Aide (NA) #1 who was the nurse aide for both Resident #135 and Resident #122 on the shift from 7/11/23 at 11:00 P.M. to 7/12/23 at 7:00 A.M. On the morning of 7/12/23, she checked on Resident #135 at

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approximately 4:20 A.M. NA #1 indicated she woke Resident #135 up and asked if he needed his brief changed, to which Resident #135 replied "yes". NA#1 indicated while she completed incontinence care for Resident #135, he told her Resident #122 had entered his room last night and touched him inappropriately on his penis. During the interview, NA #1 reported Resident #135 told her "Oh God, this is embarrassing, this is a shame, I don't want to tell anyone". When she asked Resident #135 why he had not pushed his call light during the incident to alert staff of his need for assistance, Resident #135 stated he was ashamed it was happening. NA #1 immediately left Resident #135's room to report the incident between Resident #135 and Resident #122 to Nurse #2. NA #1 indicated she had not observed Resident #122 in Resident #135's room during her shift on 7/11/23 to 7/12/23. During the interview, NA #1 indicated she had not witnessed any inappropriate sexual behavior from Resident #122 directed at staff or other residents and she had not received reports of Resident #122 going into other resident rooms without being invited.

A telephone interview was conducted on 7/31/23 at 10:36 P.M. with Nurse #2 who was the nurse for both Resident #122 and Resident #135 on the shift 7/11/23 at 11:00 P.M. to 7/12/23 at 7:00 A.M. Nurse #2 indicated NA #1 started her last rounding on residents about 4:00 A.M and after the start of her last rounds, NA #1 reported to her Resident #122 had entered Resident #135's room while he slept and touched him inappropriately. Nurse #2 stated herself and NA#1, went and told the night shift supervisor, Nurse #1, and they went to Resident #135's room to interview Resident #135. Nurse #2 stated Resident #122 was in his bed when the staff went down the

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hallway to interview Resident #135 and Resident #122 was in bed when she had last made her rounds in the hallway at approximately 3:00 A.M. During the interview with staff, Nurse # 2 stated Resident #135 told her he woke up and the bottom half of his sheet was lifted. Nurse #2 indicated Resident #135 told her Resident #122 was at the foot of his bed with his upper body leaned over Resident #135's legs, stimulating Resident #135's penis by moving his hand up and down the penis shaft. Nurse #2 indicated Resident #135 said his bedroom door was closed. Nurse #2 stated Resident #135 told Resident #122 to leave his room, or he was going to push his call light and at that time Resident #122 left Resident #135's room. Nurse #2 indicated during the interview, Resident #135 stated on a previous day (Nurse #2 indicated the date was 7/9/23 as determined by a staff party), Resident #122 had rolled into Resident #135's room with his wheelchair. Resident #135 reported he thought Resident #122 wanted to watch television with him until he noticed Resident #122 was sitting with his own hand down his pants, beside the television masturbating. During the interview, Nurse #2 indicated Resident #135 "wasn't his usual self for the rest of the shift, you could tell something had happened, you could tell he felt embarrassed telling the story and letting us know what happened." Nurse #2 was unable to explain how Resident #135 was different. During the interview, Nurse #2 indicated she completed a skin assessment on Resident #135 and did not observe any injuries. She reported that she had never witnessed Resident #122 to have inappropriate sexual behaviors towards staff or other residents. Nurse #2 stated Resident #122 was generally in his room, and she had never observed him in another resident's room.

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An interview was conducted on 8/1/23 at 2:24 P.M. with Nurse #1. Nurse #1 worked on the shift from 7/11/23 7:00 P.M. to 7/12/23 7:00P.M. as the supervisor. During the interview, Nurse #1 indicated he was unfamiliar with Resident #122 and Resident #135. Nurse #1 indicated in the early morning hours of 7/12/23, Nurse #2 and NA #1 informed him a nonconsensual sexual encounter had occurred between Resident #122 and Resident #135. Nurse #1 stated it was reported to him NA #1 had gone to Resident #135's room to provide incontinence care and observed Resident's 135's penis out the top of his brief, which Nurse #1 indicated unusual for this resident. Nurse #1 then went down the hallway to speak with Resident #135 who told him he was embarrassed about the whole situation. During the interview, Nurse #1 explained he examined Resident #135 and did not observe any injuries. He then went to Resident #122's bedroom, assisted Resident #122 into a wheelchair, relocated Resident #122 to an empty room, and assigned a nurse aide to stay with Resident #122 under 1:1 observation. Nurse #1 indicated he interviewed Resident #122 about the incident with Resident #135 and he asked Resident #122 what he had been doing that night. Nurse #1 stated Resident #122 was "beating around the bush and denied he was in Resident #135's room that night." Nurse #1 stated he left Resident #122's room and contacted both the Director of Nursing and the police department. During the interview, Nurse #1 explained Resident #135 "genuinely looked embarrassed".

An interview was attempted on 8/1/23 at 9:05 A.M. with Police Officer #1 and was unsuccessful.

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An interview was conducted on 8/1/23 at 8:43 A.M. with Occupational Therapist #1. Occupational Therapist #1 indicated he was familiar with both Resident #135 and Resident #122 because they both received therapy each morning in the therapy room. He explained Resident #122 was able to self-propel in his manual wheelchair and was able to stand, although it was very unsafe for Resident #122 to stand unassisted. The Occupational Therapist indicated he had never heard Resident #122 verbalize or behave in an inappropriate sexual manner toward the residents when he was in the therapy room. During the interview, Occupational Therapist #1 stated he recalled one morning, he was unsure of the date, Resident #135 arrived for therapy upset. Occupational Therapist #1 explained Resident #135 asked him if he had heard what had happened to him. The Occupational Therapist stated he told Resident #135 he had not heard anything, and Resident #135 described being awakened by another gentleman next to him, trying to play with his genitals. Occupational Therapist #1 indicated each morning Resident #135 showed up in the therapy room between 9:30 A.M. and 9:45 A.M. and began his therapy. Therapy was stopped at 10:00 A.M., when Resident #135 was taken to the activity's room for coffee hour before returning to the therapy room to complete his therapy. Occupational Therapist #1 indicated, the morning Resident #135 arrived to therapy upset, Resident #135 declined to go to coffee hour at the activity room. The Occupational Therapist indicated this was the only time he was aware Resident #135 had not gone to coffee hour since his admission to the facility. The Occupational Therapist was unable to explain how Resident #135 seemed upset and stated Resident #135 had not voiced

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concerns to him about concerns Resident #122 would bother him again.

A telephone interview was conducted with the Psychotherapist on 8/1/23 at 11:19 A.M. During the interview, the Psychotherapist indicated she was asked by the Social Worker to follow up with Resident #135 after an unwanted sexual encounter with another resident on 7/12/23. The Psychotherapist stated Resident #135 reported being "humiliated" and he was in the process of working through the event.

An interview was conducted on 7/31/23 at 1:39 P.M. with the Director of Nursing (DON). The DON indicated on the morning of 7/12/23, Nurse #1 called her and told her Resident #122 had entered Resident #135's room without being invited and touched Resident #135 inappropriately on his genitals. The DON stated Nurse #2 told her the incident was reported to staff on 7/12/23 shortly after 4:00 A.M., but she was unaware of the time the incident between Resident #122 and Resident #135 occurred. During the interview, the DON indicated she had never observed or received any reports of Resident #122 being sexually inappropriate The DON further stated she had not received any reports of Resident #122 going into resident rooms without being invited and she had rarely observed Resident #122 out of his assigned room. The DON explained Resident #122 was able to transfer himself into his wheelchair and he used his upper body to propel the wheelchair through the facility.

An interview was conducted on 8/1/23 at 1:49 P.M. with the Administrator. During the interview, the Administrator indicated the DON called him

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on 7/12/23 at 6:00 A.M. and made him aware of inappropriate sexual contact between Resident #135 and Resident #122. The Administrator indicated he verified Resident #122 was placed on 1:1 supervision to protect the other residents until the investigation was completed. The Administrator indicated he checked the sex offender registry and Resident #122 was not listed as an offender. The Administrator stated the facility kept Resident #122 on 1:1 supervision until he was discharged on 7/14/23 and psychological services were offered to the residents. The Administrator further indicated the Quality Assurance Performance Improvement (QAPI) team had met and discussed Resident #122. During the QAPI meeting, the Administrator indicated the group was unable to identify any warning signs Resident #122 would sexually abuse other residents in the facility.

The Administrator was notified of the Immediate Jeopardy on 8/1/23 at 3:07 P.M.

The facility provided the following credible allegation of Immediate Jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

It was reported to the Director of Nursing that there was sexual inappropriate touching between two male residents. The Director of Nursing directed the center to move the accused resident (Resident # 122) to a single room and placed him on 1:1 supervision immediately upon notification of the event. Police were notified by the nursing supervisor at the time of the event and the police

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responded with a documented time of 515am on 7/12/23 to include a report made but no charges filed. Skin assessment and incontinence care was completed by the licensed nurse on duty with no findings. The resident victim (resident # 135) was monitored throughout the duration of the shift for any changes with no changes noted. The Administrator and Medical Director were notified of the incident by the Director of Nursing upon identification of the incident. The Social Services Director interviewed resident # 135 the morning of 7/12/23 to ensure his feeling of safety and the resident reported that he felt safe. The Director of Nursing notified the center psych services professionals for additional psycho-social follow up with no additional concerns noted. APS (Adult Protective Services) return call conducted on 7/19/23 by Senior Administrator.

All alert and oriented residents with BIMs score > 11, to include male and female residents were interviewed by Social Services to determine if any other residents had been involved in a resident to resident event with inappropriate touching on 7/12/23. One other resident was identified, and Social Services followed up with Resident # 49 to ensure his feeling of safety, referred him to psych services with no negative findings and the resident reports that he feels safe in the center with only an attempted interaction noted. Social Services educated residents on Resident Rights to be Free from Abuse during their interviews. All residents received a skin check by licensed nurses/Assistant Director of Nursing on and validated by the Director of Nursing on 7/12/23. Senior Administrator reviewed the center grievance log on 7/13/23 for any abuse or negative resident interaction concerns for the last 30 days with no negative findings.

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F 600	Continued From page 18 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Education provided to staff (Full Time, Part Time and Agency staff in all disciplines Nursing, Therapy, Housekeeping, Dietary, Laundry, Activities and Administrative Staff) on Abuse Policy and Resident to Resident events on 7/12/23 with no staff working prior to education provided by the Director of Nursing/designee. This education included the types of abuse (Physical, Sexual, Emotional, Neglect and Financial) Education detailed how to report, who to report to, and prevention of abuse. Training detailed what is considered Sexual Abuse; ie: unwanted sexual contact and non contact such as sexual harassment. Education included that staff should immediately protect the resident when abuse is identified and that anyone can be a perpetrator of abuse. Newly hired and contracted staff will also receive abuse training upon hire by the Assistant Director of Nursing/designee. The education is tracked by the Director of Nursing and Assistant Director of Nursing. Center alert and oriented residents were educated by Senior Director of Nursing and Nurse Practice Educator on reporting abuse 7/19/23 with no additional concerns identified. Regional Nurse Consultant reviewed previous 60 days from date of event (7/12/23 to 5/12/23) of incident logs to include resident to resident events and state reportable incidents with no negative findings on 7/13/23.	F 600		

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Resident # 122 remained on 1:1 until discharge on 7/14/23.

Alleged date of IJ Removal 7/20/23

The credible allegation was verified on 8/1/23 as evidenced by interviews completed with staff from different departments and who worked different shifts were interviewed and verified, staff had received training about the types of abuse (physical, sexual, emotional, neglect, and financial), how to report abuse, who to report abuse to, and the prevention of abuse. Interviews with staff verified the training was provided following the incident on 7/12/23 prior to the staff being allowed to work with residents. A review was completed of educational information provided to staff during the in-service and a review of in-service staff sign-in logs. The in-service logs were reviewed, staff names were randomly selected and verified to have received training. Interviews completed with alert and oriented residents were completed and verified residents had received education from staff on their right to be free from abuse and to report incidents to staff immediately. Review of resident interviews showed one resident (#49) also reported a Resident (#122) entered his room without being invited. During an interview with Resident #49, he confirmed Social Services followed up with him. Review of residents' skin checks was completed and showed no unidentified wounds. Documentation showed the regional nurse consultant had reviewed the last 60 days of the incident log and the last 30 days of grievances.

The facility's alleged date of immediate jeopardy removal was validated to be effective 7/20/23.

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2. Resident #49 was admitted to the facility on 11/10/22 with diagnoses that included muscle weakness, acquired absence of left leg, and acquired absence of right leg.

The comprehensive MDS dated 7/14/23 showed Resident #49 was moderately cognitively impaired.

Resident #122 was admitted to the facility on 6/13/23 with diagnoses that included Parkinsons' disease, cognitive communication deficit, and spinal stenosis lumbar region with neurogenic claudication (narrowing of the space around your lower spine, which can compress the blood vessels).

The admission MDS assessment dated 6/20/23 showed Resident #122 was cognitively intact. No wandering or physical/verbal behaviors were noted.

Review of the facility's 5-day working report dated 7/18/23 showed on the night of 7/12/23 Resident #122 entered Resident #49's room and attempted to touch his penis. The report showed Resident #49 kicked Resident #122 out of his room.

Review of facility records showed a form titled "Continuous 1:1 Supervision" with Resident #122's name handwritten at the top of the form. The form showed Resident #122 had 1:1 supervision with a start date/ time of 7/12/23 at 4:30 A.M. and an end date/time of 7/14/23 at 3:00 P.M., when Resident #122 was discharged to the community from the facility.

An interview was conducted on 7/31/23 at 1:13

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P.M. with the Social Service Specialist. The Social Service Specialist stated when she arrived for work on the morning of 7/12/23, she was made aware there was a reported resident-to-resident sexual abuse allegation. The Social Service Specialist said she was instructed by management to interview all alert and oriented residents and asked each resident if another male resident made them feel uncomfortable or had another male resident entered the resident's room uninvited. The Social Service Specialist stated when she asked Resident #49 those questions he responded "yes" to both questions. The Social Service Specialist stated Resident #49 told her Resident #122 had entered his room the previous night and asked to watch television with him. Resident #49 told the Social Service Specialist, Resident #122 self-propelled his wheelchair to the left side of Resident #49's bed and moved his bedside table out of the way, which allowed Resident #122 to move his wheelchair closer to the bed. The Social Service Specialist was told by Resident #49, after Resident #122 moved the bedside table out of the way, Resident #122 laid his hand on top of a blanket on Resident #149's penis. The Social Service Specialist stated Resident #49 told Resident #122 "I don't play that" and told him to leave. The Social Service Director indicated when she asked Resident #49 why he didn't report the incident to staff, he replied "I handled it and took care of it. I can protect myself." During the interview, the Social Service Specialist stated prior to this investigation, she had not received reports from staff or residents that Resident #122 had entered other resident's rooms without being invited or had inappropriately touched other residents.

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An interview was conducted on 7/31/23 at 10:40 A.M. with Resident #49. During the interview, Resident #49 stated about two to three weeks ago, Resident #122 entered his room and without being given permission, touched his penis. Resident #49 stated he was unsure of the exact date the incident happened, but stated it was at approximately 11:30 P.M. Resident #49 stated he was lying in his bed, under a blanket and sheet, watching television when Resident #122 self-propelled his wheelchair into Resident #49's room without being invited. Resident #122 wheeled himself passed Resident #49's bed, (the first bed on the right), to the second bed, stopped his wheelchair near the foot of the bed and looked at Resident #49's roommate. Resident #49 stated he asked Resident #122 what he was doing, because his roommate was asleep. Resident #122 did not respond and did not disturb Resident #49's roommate. Resident #49 stated Resident #122 turned his wheelchair around to face the bedroom door, rolled to the foot of Resident #49's bed and started watching television. The television was positioned on a dresser lined up at the foot of Resident #49's bed. There was a walkway wide enough for Resident #122's wheelchair between the foot of the bed and the dresser. Resident #49 explained Resident #122 did not stay at the foot of the bed long, he was unsure the length of time, when Resident #122 self-propelled his wheelchair down the left side of Resident #49's bed. Resident #122 stopped the wheelchair at an over bed table that was positioned halfway the bed over Resident #49's waist and moved the over bed table away from Resident #49's bed. Resident #49 explained Resident #122 laid his hand on Resident #49's groin and tried to manipulate his penis through the blanket. Resident #49 indicated he told

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Resident #122 "I don't play that s ..." and told him he'd better leave. Resident #122 asked Resident #49 "You're not going to hit me, is you" and when Resident #49 answered "no", Resident #122 left his room. Resident #49 indicated he was unsure where Resident #122 went when he left his room. During the interview, Resident #49 stated he had never had anyone touch him inappropriately like that before and he did not like it. He said he did not tell the nurse when she went to check on him after the incident because it was late and "the girls can't do anything about it." Resident #49 indicated he told the Social Service Specialist about the event the following day when she went into his room and asked him questions. Resident #49 stated the police were contacted and they came to the facility to interview him. Resident #49 did not provide a reason to why he did not press charges with the police against Resident #122. Resident #49 verbalized he was able to protect himself and he felt safe in the facility. Resident #49 stated Resident #122 had never been invited into his room and he had only seen Resident #122 in the hallway a few times but had not spoken with him.

Attempted to interview Resident #49's roommate on 7/31/23 at 11:25 A.M. The roommate was severely cognitively impaired per the admission MDS dated 6/16/23 and was unable to provide any information about the allegation.

At the time of the investigation, Resident #122 no longer resided in the facility and was unable to be interviewed.

A telephone interview was conducted on 8/1/23 at 12:19 A.M. with Nurse #2 who was the nurse for both Resident #49 and Resident #122 on the shift

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from 7/11/23 at 11:00 P.M. to 7/12/23 at 7:00 A.M. During the interview, Nurse #2 stated she checked on residents about every two hours, in addition to when she had walked through the halls to complete other assigned tasks. Nurse #2 indicated she had observed Resident #122 in his bed throughout her shift, and never in the hallway or in another resident's room. During the interview, Nurse #2 confirmed Resident #49 had not reported to her Resident #122 had entered his room during the night. Nurse #2 indicated Resident #49's behaviors were at his baseline, and she was unaware an incident had occurred on 7/11/23 until she returned to work the evening of 7/12/23.

An interview was conducted on 8/1/23 at 12:52 P.M. with Nurse #9. During the interview, Nurse #9 indicated when she arrived for work on 7/12/23 she was made aware of an incident where a resident was inappropriately touched by Resident #122 that morning. Nurse #9 indicated she was made aware a second resident (Resident #49) had also been touched inappropriately by Resident #122 and was told by the Director of Nursing to call the police. During the interview, Nurse #9 stated she had observed Resident #122 around the facility. He had no difficulty propelling himself in a wheelchair and had not been observed to be sexually inappropriate with staff or residents. During the interview, Nurse #9 indicated Resident #49 had the ability to speak for himself and had good relationships with the staff. Nurse #9 stated she was unsure why Resident #49 had not spoken up and reported the incidents with Resident #122. Nurse #9 further explained, "I'm not sure he (Resident #49) would have ever said anything if he hadn't been asked."

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Review of a police report completed by Police Officer #2, dated 7/12/23 at 3:22 P.M. showed a narrative section that read "Due to (Resident #49). having a roommate, (Nurse #9) escorted us to the conference room for privacy. Once in the conference room I asked (Resident #49) to inform me about the incident. (Resident #49) stated around 2300 or 2330 hours (11:00 P.M. or 11:30 P.M.), while lying in his bed, a unknown white male entered his room in a wheelchair. (Resident #49) stated the male stated he 'wanted to look at the T.V.' (Resident #49) stated he allowed the male to watch with him, but then the male subject came over to the side of (Resident #49's) bed, moved his bedside table and began to rub (Resident #49's) penis. (Resident #49) stated he pushed the male away while saying "Man I don't play that s ...." The unknown male then left the room and asked if (Resident #49) was going to hit him. (Resident #49) stated he responded by saying no, but to get out of his room. (Resident #49) told me he did not wish to pursue charges. The suspect was confirmed to be (Resident #122) by the previous report and by (Nurse #9).

An interview was attempted on 8/1/23 at 9:05 A.M. with Police Officer #2 and was unsuccessful.

An interview was conducted on 7/31/23 at 1:39 P.M. with the Director of Nursing (DON). During the interview, the DON indicated during an investigation for resident-to-resident sexual abuse, staff interviewed all alert and oriented residents and asked if they had been inappropriately touched by another male resident. The DON stated, during these interviews Resident #49 stated he had. The DON interviewed Resident #49 and learned Resident

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F 600	Continued From page 26 #122 had inappropriately touched Resident #49's private area. The DON stated Resident #49 told Resident #122 "he didn't play that, and he needed to get the hell out of here." Resident #122 left Resident #49's room. The DON indicated at the time the facility learned about the incident with Resident #49, Resident #122 was already on 1:1 observation with an assigned nurse aide. During the interview, the DON stated Resident #122 remained on 1:1 observation until his discharge on 7/14/23. She further stated she interviewed Resident #49 and he verbalized he felt safe in the facility. During the interview, the DON indicated she had never observed or received any reports of Resident #122 being sexually inappropriate The DON further stated she had not received any reports of Resident #122 going into resident rooms without being invited and she had rarely observed Resident #122 out of his assigned room. The DON explained Resident #122 was able to transfer himself into his wheelchair and he used his upper body to propel the wheelchair through the facility.	F 600		
F 607 SS=D	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 paragraph §483.95,	F 607		8/22/23

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F 607	Continued From page 27 §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 and staff and resident interviews, the facility failed to implement their policy for reporting an allegation of sexual abuse to the state agency within 2 hours for 1 of 3 residents reviewed for alleged sexual abuse investigations (Resident #49). Findings included: The facility abuse policy, last revised 10/24/22, read in part, "Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following. (Refer to External Abuse reporting Requirements table). 7.1 Enter allegations into PCC Risk Management Portal. 7.2 Report allegation involving abuse physical, verbal, sexual, mental) not later than 2 hours after the allegation is made. 7.3 Report allegation to the	F 607	F 607 Develop/Implement Abuse/Neglect Policies 1) Social Services met with Resident # 49 to ensure his feeling of safety, the resident reports that he feels safe in the center. Resident # 49 was also referred to psych services for follow up but refused to be seen. 2) Information regarding resident #49□s allegation was included in an investigation summary submitted 7/18/23 for resident #135. An initial and final report was submitted to the N.C. Department of Health & Human Services and Adult Protective Services on 8/15/23. 3) Education provided to the Administrator, Director of Nursing and	

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F 607	Continued From page 28 appropriate state and local authority(s) involving neglect, exploitation, mistreatment (including injuries of unknown source), suspected criminal activity and misappropriation of patient property not later than two (2) hours after the allegation is made if the event results in serious bodily injury." Resident #49 was admitted to the facility on 11/10/22 with diagnoses that included muscle weakness, acquired absence of left leg, and acquired absence of right leg. The comprehensive MDS dated 7/14/23 showed Resident #49 was moderately cognitively impaired. Review of a statement from Resident #49 dated July 12, 2023, revealed "Resident #49 indicated he said that man up and the hall came in here. I was watching TV and he asked if he could watch TV. I told him it's okay. Resident #49 reports Resident #122 then moved the bedside table and touched his penis on top of the covers. I told him I don't play that sh--- and he better get the h--- out of my room, and he left." Resident #49 indicated that Resident #122 had ever done this before and Resident #49 indicated No. Resident #49 reports that he did not tell anyone when it happened because he felt he took care of it. " Resident #49 was interviewed on 07/19/23 at 10:30 am and stated he had been touched by Resident #122 during the evening on 07/11/23 and was not sure of the time. He had reported this information to the Social Worker (SW) on 07/12/23. Resident #49 indicated that Resident #122 had touched his penis from on top of the blanket. Resident #49 indicated he felt safe in the facility and knew how to protect himself.	F 607	Social Services by the Senior Administrator regarding the center□s abuse policies and reporting requirements on 8/15/23. The Administrator provided the same training to the Social Services Director on 8/16/23. The Nurse Practice Educator will conduct abuse training with center staff to review the abuse reporting policy. Nurse practice Educator/designee will also be providing the education for newly hired nurses, newly hired certified nursing assistants as well as newly contracted agency nurses and certified nursing assistants. 4) The administrator will review grievances and risk events five times weekly for six weeks to validate any allegation of abuse or neglect is reported and investigated timely. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. The Administrator will be responsible for this plan. 5) Date of compliance 8/22/23	

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F 607	Continued From page 29 An interview was conducted with the Social Worker (SW)on 07/19/2023 at 11:00 am, and she indicated that she had interviewed residents in the facility on 7/12/23 regarding sexual abuse allegation by a resident to another resident. During her investigation Resident #49 alleged he had been touched inappropriately by Resident #122. The SW indicated that this information was given to the Director of Nurse and the Administrator on 07/12/23. The SW stated a part of the facility policy was to interview all residents after any allegation of resident abuse. Review of facility's Initial Allegation Reports to the state agency revealed there was not a report completed for Resident #49's allegation of sexual abuse on 7/12/23. During an interview with the Director of Nursing (DON) on 07/20/23 at, she indicated that her expectation for resident-to-resident sexual abuse was for staff to follow the facility abuse protocols and make sure all residents are safe. During an interview with the Administrator on 07/20/23 1:30pm, he indicated that all staff members need to follow the facility abuse protocols and that all residents are to be safe. He also indicated that the facility has a zero tolerance of abuse.	F 607		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		8/22/23

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F 657	Continued From page 30 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to revise the comprehensive care plan in the area of transfer status for 2 (Resident #106 and Resident #30) of 30 residents reviewed for care plan revision. The findings included: Resident #106 was admitted on 4/7/22 with cumulative diagnoses of Congestive Heart Failure and acute/chronic renal failure. Review of Resident #106's Activities of Daily Living (ADL) care plan dated 5/25/22 read she	F 657	F 657 Care Plan Revisions 1) Resident # 106 and Resident # 30 have had their care plans updated to reflect their current assessed transfer status. 2) All residents have the potential to be affected. Nursing Leadership completed a 100% audit of all current residents Lift/Transfer Assessments and Care Plans to ensure that they reflected the same level of care/support required. 3) Nurse Practice Educator provided	

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F 657	Continued From page 31 was an total assistance of 2 for transfers using sit to stand lift. Her annual Minimum Data Set (MDS) dated 5/17/23 indicated Resident #106 was cognitively intact, experienced no falls, requiring extensive staff assistance of 2 for transfers. Review of Resident #106's July 2023 Physician orders did not include an order for Resident #106's transfer needs. Review of a nursing note dated 7/15/23 at 11:37 AM read Resident #106 was being transferred from the bed to her wheelchair with 1 staff assistance when her knee gave out and she was lowered to the floor. Review of the incident report investigation note dated 7/17/23 read the root cause was she was transferring from the bed to her wheelchair and her leg gave out and Resident #106 was lowered to the floor. The intervention was 2 staff assistance with transfers when she appeared weak documented by Nurse Supervisor #1. Review of the revised ADL care plan on 7/17/23 read Resident #106 required 2 staff assistance with transfers when she appeared weak. The care plan was revised by Nurse Supervisor #1. An interview was completed on 7/18/23 at 11:34 AM with the Director of Nursing (DON) and Nurse Supervisor #1. The DON and Nurse Supervisor #1 were unable to explain what the new intervention of 2 staff assistance meant regarding her transfer status. Review of a Lift Transfer Evaluation dated	F 657	education to all licensed staff and nurses aids on the Lift Transfer Assessment and Care Planning of assessed transfer/support needs. Education included ensuring that the care plan is followed to ensure resident safety in transfers. Nurse practice Educator/designee will also be providing the education for newly hired nurses, newly hired certified nursing assistants as well as newly contracted agency nurses and certified nursing assistants. 4) Nursing leadership to audit 5 random care plans per week to ensure that they match the Lift/Transfer Assessment. Nursing Leadership to audit 5 random resident transfers per week to ensure that the correct assessed and care planned level of care/support is provided during the transfer. Result of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance The Director of Nursing will be responsible for this plan. 5) Date of compliance 8/22/23	

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7/18/23 at 9:28 AM read Resident #106 was now a total mechanical sling lift transfer. This was completed by Nurse Supervisor #1.

Review of Resident #106's care plan on 7/18/23 at 9:28 AM read she was now care planned as a total mechanical lift. The care plan was revised by Nurse Supervisor #1

Another interview was completed on 7/18/23 at 11:34 AM with the DON and Nurse Supervisor #1. Nurse Supervisor #1 stated after speaking with the aides earlier this morning, they reported Resident #106 required more assistance with transfers due to her weight gain and decreased mobility. She stated she completed the Lift Transfer Evaluation earlier this morning and changed her to a total lift for transfers.

An interview was completed on 7/20/23 at 12:04 PM with the DON and Interim Administrator. The DON stated it was her expectation that Resident #106's care plan reflect the accurate and most current method of safe transfers.

2.Resident #30 was admitted on 3/9/2021 with diagnoses that included hemiparesis secondary to cerebral vascular accident (stroke).

Resident #30's quarterly Minimum Data Set (MDS) dated 5/30/2023 indicated the resident had mild cognitive impairment, had functional limitation of one upper and one lower extremity, and was not steady and only able to stabilize with human assistance when moving from surface to surface or seated to standing.

Resident #30's comprehensive care plan was last revised 6/13/2023 had a focus for assistance with activities of daily living. Interventions included

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providing extensive assistance of 1-2 persons for bed mobility, toileting, dressing, and bathing. The care plan did not address how the resident transfers from surface to surface or bed to wheelchair.

The resident's quarterly MDS dated 11/8/2022 indicated the resident transferred with extensive assistance by 2 persons.

The resident's quarterly MDS dated 3/2/2023 indicated the resident transferred with limited assistance of one person.

The resident's medical record included quarterly lift-transfer-repositioning evaluations completed by nursing staff. They were as follows:

On 12/9/2022 No equipment needed for positioning in bed. Lift transfers. Needs total lift/bariatric/large.
On 3/9/2023 Use friction reducing device to position in bed. Lift transfers Needs total lift/non-bariatric/XL.

On 7/20/2023 at 9:35 AM an interview was conducted with the MDS nurse who also revised and updated the comprehensive care plans. She reviewed Resident #30's care plan and acknowledged it did not address how the resident should be transferred. She further stated the care plan should have addressed how the resident transferred and she would update the care plan.

On 7/20/2023 at 12:22PM and an interview was conducted with the Director of Nursing (DON). She stated the MDS, the care plan, and the care guide (Kardex) should be consistent in addressing how the resident transfers.

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F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff, Nurse Practitioner and Medical Director (MD) interviews, the facility failed to hold an anticoagulant for a resident (Resident #345) who had oral surgery resulting in significant bleeding and emergency treatment, the facility also failed to wait for a nurse to asses a resident for injuries prior to moving her up off the floor (Resident #106). This was for 2 of 2 residents reviewed for standards of care. The findings included: 1. Resident #345 was admitted on 12/23/2021. The resident's discharge Minimum Data Set (MDS) dated 6/15/2023 indicated the resident was cognitively intact and required assistance with activities of daily living. The resident's medical record contained a visit summary from the dentist dated 4/14/2023. The summary noted the resident needed referral to oral surgeon for extraction (removal) of all maxillary teeth and recommended complete denture for maxillary and partial denture for	F 684	F 684 Quality of Care 1) Resident # 345 is no longer a resident of Siler City Center. Resident # 106 is currently being transferred as Assessed and Care Planned with a Mechanical Lift. 2) All residents on anticoagulant medications have potential to be affected. Nursing Leadership completed an audit of all current residents on anticoagulant medications for any medical procedures in the last 30 days to determine if their anticoagulants had been placed on hold. All residents have potential to be affected. Nursing Leadership completed a 100% audit of all current residents who have had a fall in the last 30 days to determine if licensed staff assessed the residents prior to moving them off the floor. 3) Nurse Practice Educator provided education for licensed staff on ensuring that when residents are scheduled for medical procedures that the Providers review for the need to hold anticoagulant	8/22/23

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F 684	Continued From page 35 mandibular. The summary noted the resident was on Eliquis (anticoagulant). The resident's medical record contained a physician's order for Eliquis 5 milligrams (mg) twice daily for treatment of atrial fibrillation (irregular heart rhythm) with a start date of 3/18/2022. Resident #345's medical record contained a report of consultation from an oral surgeon dated 5/5/2022. The report read," removed all decayed teeth and removed lesion on right side of tongue. Sutures placed and will resolve on their on." The resident's progress notes by Nurse #7 dated 5/5/2022 3:01PM read in part, "resident noted to have moderate amount of bleeding since return. Encouraged resident to keep applying gauze and pressure." Nurse #7 documented the following on 5/5/2022 at 3:48PM, "resident returned from dental appointment. Had numerous teeth pulled resulting in no teeth in mouth as well as tongue mass removal. Resident noted to have moderate amount of bright red bleeding since return, starting to clot at this time." On 5/5/2022 at 6:29PM Nurse #7 documented bleeding continued but as slower pace. Also noted resident complained of swallowing blood. On 5/6/2022 at 9:12AM Nurse #8 noted that resident continued to bleed from mouth. She encouraged resident to keep gauze in place. A progress noted dated 5/6/2022 at 12:26PM by Nurse #8 indicated the physician had been in to	F 684	medications. Nurse Practice Educator provided education for the nursing staff, licensed and nurses aids regarding ensuring that a nurse assesses all residents who fall prior to the resident being moved or assisted off the floor. Nurse practice Educator/designee will also be providing the education for newly hired nurses, newly hired certified nursing assistants as well as newly contracted agency nurses and certified nursing assistants. 4) Nursing leadership to audit all residents with scheduled procedures weekly for the next 30 days then randomly thereafter to ensure that Primary Providers have reviewed medications to determine if any medications need to be placed on hold. Nursing Leadership to audit all falls weekly for the next 30 days and randomly thereafter to ensure that a licensed nurse has assessed the resident prior to being moved and assisted off the floor. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. The Director of Nursing will be responsible for this plan. 5) Date of compliance 8/22/23	

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evaluate resident and gave new order for resident to be transported to the Emergency Department for continued bleeding from oral surgery.

An after-visit summary from the Emergency Department Dated 5/6/2022 indicated the resident was seen for hemorrhage after dental procedure that was now controlled. The resident's laboratory findings were normal. The resident was made NPO (nothing by mouth) and pressure was applied to the gums. Three hours after the bleeding stopped, the resident was discharged back to the facility. The after-visit summary instructed to hold Eliquis until 5/9/2022.

Attempts to contact Nurse #7 were not successful.

A phone interview was conducted with Nurse #8 on 7/19/2023 at 2:12PM. The nurse stated she vaguely recalled the incident. It occurred over a year ago and she did not recall if she administered the Eliquis (anticoagulant).

Resident #345's May 2022 Medication Administration Record (MAR) indicted both doses (9:00AM and 9:00PM) of the resident's Eliquis were held 5/4/2022 as well as the 9:00AM dose on 5/5/2022. However, the MAR indicated the resident received the evening dose (9:00PM) on 5/5/2022 by Nurse #7. Resident #345's MAR also indicated the resident received the morning (9:00AM) dose of Eliquis on 5/6/2022 by Nurse #8.

On 7/19/2023 at 1:26 PM an interview was conducted with the Medical Director and the Director of Nursing (DON). The Medical Director

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stated he was made aware of the resident's oral surgeon visit at the last minute and he did request the Eliquis be held the day before and the day of the procedure. He did not recall an order to hold the Eliquis after the procedure. He stated he was under the impression the resident was just having extractions, he was not aware a mass under the tongue was being biopsied. The Medical Director stated he did not get a call from the facility the night of the procedure, but he did get a call the morning after. He requested the staff send the resident to the Emergency Room due to staff reports of excessive bleeding.

On 7/20/2023 at 9:59 AM an interview was conducted with Nurse Practitioner #1. She stated Resident #345 had been added to her case load at the beginning of May 2022. The morning of 5/6/2023 she went into examine the resident due to staff reports of bleeding. She stated it was the first time she had seen the resident and had not had an opportunity to review his history or medication. She stated she walked into the room and found him bleeding heavily from the mouth. She did not feel like a dental procedure would cause bleeding to that extent and therefore requested staff send him out to the Emergency Room. She was not aware he was receiving Eliquis. Nurse Practitioner #1 stated the nurses did not call her during the night or that morning to notify her of the resident's bleeding. She further stated the staff may not have know to call her since the resident had just been added to her caseload.

On 7/20/2023 at 12:22PM an interview was conducted with the DON. She stated she expected staff to hold an anticoagulant and notify the Nurse Practitioner or Medical Director any

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time a resident has active bleeding.
2. Resident #106 was admitted on 4/7/22 with cumulative diagnoses of Congestive Heart Failure and acute/chronic renal failure.

Review of Resident #106's comprehensive care plan read she was a total staff assistance of 2 for transfers using sit to stand lift on 5/26/22.

Her annual Minimum Data Set (MDS) dated 5/17/23 indicated Resident #106 was cognitively intact, experienced no falls, requiring extensive staff assistance of 2 for transfers.

Review of a nursing note dated 7/15/23 at 11:37 AM read Resident #106 was being transferred from the bed to her wheelchair with 1 staff assistance when her knee gave out and she was lowered to the floor. There were no complaints of pain so she was lifted off the floor using a total mechanical lift. This note was written by Nurse #3.

Review of the incident report investigation note dated 7/17/23 read the root cause was Resident #106 was transferring from the bed to her wheelchair when her leg gave out and she was lowered to the floor. The intervention was 2 staff assistance with transfers when she appeared weak. There was no documentation as to how Resident #106 was to be transferred. The investigation note was documented by Nurse Supervisor #1.

An interview with Resident #106 was completed on 7/17/23 at 11:30 AM. She stated the aide was transferring her by standing her up and pivoting her into the wheelchair. She stated that was how they had been transferring her for "long time".

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She stated once the aides got her up into her wheelchair the nurse came in and assessed her for injuries. Resident #106 stated she did not think she was injured at the time but now her left ankle was a little painful.

A telephone interview was completed with Nursing Assistant (NA) #2 on 7/19/23 at 11:35 AM. She stated she was assigned Resident #106 at the time of her fall on 7/15/23 and asked NA #3 to assist her with transferring Resident #106 when her legs just gave out and was assisted to the floor. NA #2 stated she did not think to get a nurse to assess Resident #106 prior to transferring her off the floor because she reported no injuries.

An interview was completed on 7/19/23 at 12:30 PM with NA #3. She stated NA #2 asked her to assist with transferring Resident #106 from the bed to her wheelchair when Resident #106's leg gave out and she was assisted to the floor. She stated they lifted her off the floor with the total mechanical lift before letting the nurse know she was on the floor. She stated Nurse #3 reminded her not to move a fallen resident until a nurse completed an assessment.

A telephone interview was completed on 7/19/23 at 11:25 AM with Nurse #3. She stated Nurse Supervisor #2 came and got her to go with her to Resident #106's room due to a reported fall. She stated when she got into the room, Resident #106 had already been moved from the floor into her wheelchair using a total mechanical lift. Nurse #3 stated she reminded aides not to move a fallen resident until they were assessed by a nurse. She stated Resident #106 reported no pain and appeared absent of injuries.

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F 684	Continued From page 40 A telephone interview was completed on 7/19/23 at 11:20 AM with Nurse Supervisor #2. She recalled the fall on 7/15/23 for Resident #106. She stated NA #2 came to her and told her she was needed in Resident #106's room. Nurse Supervisor #2 stated when she arrived in the room, Resident #106 had already been moved from the floor into her wheelchair using a total mechanical lift. An interview was completed on 7/18/23 at 11:34 AM with the Director of Nursing (DON). The DON stated it was her expectation that Resident #106 be transferred as care planned and how it appeared on the Kardex transferred using the safest method to prevent falls and injuries to Resident #106 and the staff. She also stated she expected a fallen resident was not to be moved prior to a nursing assessment for injuries. An interview was completed on 7/19/23 at 1:07 PM with the MD. He stated he expected no resident including Resident #106 to be moved off the floor from a fall until that resident was evaluated by a nurse and determined to have no injuries.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		8/22/23

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F 689	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on resident, staff, Medical Director (MD) and Therapy Director interviews and record review, the facility failed to transfer a resident using a sit to stand lift (a mechanical lift that assist a resident with limited mobility in standing up from a seated position) as care planned and according to the physical therapy discharge summary (Resident #106). The facility also failed to transfer a resident requiring a total mechanical lift (portable total body lift used to minimize physical effort) for transfers resulting in a fall without injury (Resident #30). This was for 2 of 8 residents reviewed for accidents. The findings included: 1. Resident #106 was admitted on 4/7/22 with cumulative diagnoses of Congestive Heart Failure and acute/chronic renal failure. Review of Resident #106's comprehensive care plan read she was a total staff assistance of 2 for transfers using sit to stand lift on 5/26/22. Review of Resident #106's latest Physical Therapy (PT) Discharge Summary dated 4/5/23 read she continued to require a sit to stand lift for transfers. An interview on 7/18/23 at 11:20 AM with the Therapy Director. He verified the PT discharge recommendation on 4/5/23 was to continue using the sit to stand lift for transfers. Her annual Minimum Data Set (MDS) dated 5/17/23 indicated Resident #106 was cognitively intact, experienced no falls, requiring extensive staff assistance of 2 for transfers. Her weight was	F 689	F 689 Incidents/ Accidents 1) Resident # 106 and Resident # 30 have had their Lift/Transfer Assessments and Care Plans updated to reflect their current assessed transfer status, and are both being transferred according to their Assessments and Care Plans. 2) All residents have the potential to be affected. Nursing Leadership completed a 100% audit of all current residents Lift/Transfer Assessments and Care Plans to ensure that they reflected the same level of care/support required. 3) Nurse Practice Educator provided education to all licensed staff and nurses aids on the Lift Transfer Assessment and Care Planning of assessed transfer/support needs. Education included ensuring that the care plan is followed to ensure resident safety in transfers. Nurse Practice Educator/designee will also be providing the education for newly hired nurses, newly hired certified nursing assistants as well as newly contracted agency nurses and certified nursing assistants. 4) Nursing leadership to audit 5 random care plans per week to ensure that they match the Lift/Transfer Assessment. Nursing Leadership to audit 5 random resident transfers per week to ensure that the correct assessed and care planned level of care/support is provided during	

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F 689	Continued From page 42 308 pounds. Review of Resident #106's July 2023 Physician orders did not include any orders for Resident #106's transfer needs. Review of Resident #106's electronic medical record read she weighed 235.6 pounds on 8/30/22 and on 7/3/23 Resident #106's recorded weight was 326.6 for a 101-pound weight gain in a year. Review of a nursing note dated 7/15/23 at 11:37 AM read Resident #106 was being transferred from the bed to her wheelchair with 1 staff assistance when her knee gave out and she was lowered to the floor. There were no complaints of pain so she was lifted off the floor using a total mechanical lift. This note was written by Nurse #3. An interview with Resident #106 was completed on 7/17/23 at 11:30 AM. She stated the aide was transferring her by standing her up and pivoting her into the wheelchair. She stated that was how they had been transferring her for "long time". A telephone interview was completed with Nursing Assistant (NA) #2 on 7/19/23 at 11:35 AM. She stated she was assigned Resident #106 at the time of her fall on 7/15/23 and asked NA #3 to assist her with transferring Resident #106 using stand and pivot method when her legs just gave out. She stated Resident #106 was so heavy, they assisted her down to the floor. She stated the electronic Kardex read how to transfer Resident #106 but she did not look at it and Resident #106 stated that's how they always transferred her.	F 689	the transfer. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. The Director of Nursing will be responsible for this plan. 5) Date of compliance 8/22/23	

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An interview was completed on 7/19/23 at 12:30 PM with NA #3. She stated NA #2 asked her to assist in standing and pivot transfer of Resident #106 from the bed to her wheelchair when Resident #106's leg gave out and she was assisted to the floor. She stated they lifted her off the floor with the total mechanical lift before letting the nurse know she was on the floor. She stated the electronic Kardex read how to transfer Resident #106 but she did not look at it and Resident #106 stated that's how they always transferred her.

A telephone interview was completed on 7/19/23 at 11:25 AM with Nurse #3. She stated Nurse Supervisor #2 came and got her to go with her to Resident #106's room due to a reported fall. She stated when she got into the room. She stated Resident #106 reported no pain and appeared absent of injuries. Nurse #3 stated she understood that according to NA #2 and NA #3 she was a stand and pivot for transfers but she did not look at her Kardex or care plan to make sure they transferred her the correct method.

A telephone interview was completed on 7/19/23 at 11:20 AM with Nurse Supervisor #2. She recalled the fall on 7/15/23 for Resident #106. She stated NA #2 came to her and told her she was needed in Resident #106's room. Nurse Supervisor #2 stated when she arrived in the room, Resident #106 had already been moved from the floor into her wheelchair using a total mechanical lift. She stated she was unsure of Resident #106's transfer status and she did not look at the Kardex or care plan to find out.

An interview was completed with NA #7 on

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7/18/23 at 10:40 AM. She stated she understood that Resident #106 was a stand and pivot transfer, but she used to be able to stand and help out but due to her weight and decreased mobility it was more difficult and unsafe. She stated she had not notified anyone of Resident #106's transfer status concerns. NA #7 stated they should b referring to the Kardex to see the correct way to transfer any resident.

An interview was completed with NA #8 on 7/18/23 at 10:45 AM. She stated it had gotten unsafe to transfer Resident #106 by her standing and pivoting. She stated she was not aware Resident #106 was to be lifted using the sit to stand lift. She stated at one time she was a total mechanical lift for transfers but that was changed about 9 months ago. She stated she had not notified anyone of Resident #106's transfer status concerns. NA #8 stated they should be referring to the Kardex to see the correct way to transfer any resident.

Review of a Lift Transfer Evaluation dated 7/18/23 at 9:28 AM read Resident #106 was now a total mechanical lift transfer completed by Nurse Supervisor #1.

Review of the incident report investigation note dated 7/17/23 read the root cause was Resident #106 was transferring from the bed to her wheelchair when her leg gave out and she was lowered to the floor. The intervention was 2 staff assistance with transfers when she appeared weak. There was no documentation as to how Resident #106 was to be transferred. The investigation note was documented by Nurse Supervisor #1.

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An interview was completed on 7/18/23 at 11:34 AM with the Director of Nursing (DON) and Nurse Supervisor #1. The DON and Nurse Supervisor #1 were unable to explain what the new intervention of 2 staff assistance meant regarding her transfer status. Nurse Supervisor #1 stated after speaking with the aides on 7/18/23, they reported Resident #106 required more assistance with transfers due to her weight gain and decreased mobility. She stated she completed the Lift Transfer Evaluation after we discussed it on 7/18/23 and changed her to a total lift for transfers. The DON stated it was her expectation that Resident #106 be transferred as care planned and how it appeared on the Kardex and expected adequate oversight to ensure new aides and staffing agency aides knew where to look for transfer status.

An interview was completed on 7/19/23 at 1:07 PM with the MD. He stated it was his expectation that residents be routinely evaluated for the safest method of transfer and especially with Resident #106 given her weight gain.

2. Resident #30 was admitted on 3/9/2021 with diagnoses that included hemiparesis secondary to cerebral vascular accident (stroke).

Resident #30's quarterly Minimum Data Set (MDS) dated 5/30/2023 indicated the resident had mild cognitive impairment, had functional limitation of one upper and one lower extremity, and was not steady and only able to stabilize with human assistance when moving from surface to surface or seated to standing.

Resident #30's comprehensive care plan was last revised 6/13/2023 had a focus for assistance with activities of daily living. Interventions included

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providing extensive assistance of 1-2 persons for bed mobility, toileting, dressing, and bathing. The care plan did not address how the resident transfers from surface to surface or bed to wheelchair.

The resident's medical record included quarterly lift-transfer-repositioning evaluations completed by nursing staff. They were as follows:

On 12/9/2022 No equipment needed for positioning in bed. Lift transfers. Needs total lift/bariatric/large.
On 3/9/2023 Use friction reducing device to position in bed. Lift transfers Needs total lift/non-bariatric/XL.

An incident report dated 1/2/2023 indicated Resident #30 experienced a fall when being transferred from wheelchair to bed. He was assisted to the floor by NA#11. The resident was not injured.
On 7/19/2023 at 8:57AM and interview was conducted with Resident #30. He stated when he was first admitted to the facility, he required a lift to transfer. He stated he can transfer without a lift at this time, and he does not recall when that changed. He further stated he was not being transferred by a lift when he missed the bed and slid to the floor in December. He was attempting to transfer with the assistance of one Nurse Assistant (NA). He confirmed the NA was NA#11.

An interview was conducted with NA#11 on 7/18/2023 at 11:11AM. She stated she was not using a lift to transfer the resident when he missed the bed and slid to the floor back in December. She did not think the resident required a lift to transfer. She further stated she looked at

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F 689	Continued From page 47 the care guide (Kardex) to determine how the resident transfers. A review of Resident #30's care guide (Kardex) did not reveal how the resident transferred. She stated the care guide (Kardex) is generated from the care plan. If the resident's method of transfer is not included in the care plan, it will not be found in the care guide. On 7/20/2023 at 9:35 AM an interview was conducted with the MDS nurse who also revised and updated the comprehensive care plans. She reviewed Resident #30's care plan and acknowledged it did not address how the resident should be transferred. Therefore, the care guide (Kardex) would not have indicated how the resident was to be transferred. She further stated the care plan should have addressed how the resident transferred and she would add it to the resident's care plan. On 7/20/2023 at 12:22PM and interview was conducted with the Director of Nursing (DON). She stated the NA should refer to the care guide (Kardex) or the care plan to determine how a resident can transfer. If those resources do not address how the resident transfers, the NA should ask nursing staff to clarify. She further stated the MDS, the care plan, and the care guide (Kardex) should be consistent.	F 689		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		8/22/23

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F 757	Continued From page 48 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with resident, staff, and Medical Director, the facility failed to discontinue a resident's antiepileptic medication per neurologist recommendation for 2 months in 1 of 6 residents (Resident #95) reviewed for unnecessary medications. The findings included: Resident #95 was admitted to the facility 6/8/2021 with diagnoses that included a history of seizures. The resident's annual Minimum Data Set (MDS) dated 5/1/2023 indicated he was cognitively intact. Resident #95's comprehensive care plan was last revised 6/22/2023 and included a focus for risk of seizure activity. An interview was conducted with Resident #95 on	F 757	F 757 Unnecessary Medications 1) Resident # 95 had seizure medication discontinued on 6/28/23. 2) All residents have the potential to be affected. Nursing Leadership completed a 100% audit of all current residents who have had outside appointments in the last 30 days to ensure that all recommendations have been carried out with follow up with the primary provider. 3) Nurse Practice Educator provided education for licensed staff on ensuring that when residents go out for consultations with external providers that after visit summaries are reviewed upon return for any new recommendations/orders. Nurse Practice Educator/designee will also be providing the education for newly hired nurses,	

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F 757	Continued From page 49 7/17/2023 at 9:38AM. He stated he knew the seizure medication had been discontinued by the neurologist and he made the nurses aware. The nurses told him they did not have a copy of the after-visit summary. Resident #95 stated he gave the summary to the nurse at the nurse station when he returned to the facility on 5/4/2023. He finally became frustrated and refused to take the medication on 6/27/2023. At that time, he pulled up his after-visit summary on his MyChart (electronic medical record for patients) and showed Nurse #6 where the levetiracetam had been discontinued. The facility discontinued the medication at that time. The resident's medical record included a neurology after visit summary dated 5/4/2023. The medical record indicated the summary was uploaded into the medical record on 5/16/2023. The summary by the neurologist indicated the resident had not had any seizure activity since his hospitalization and recommended the seizure medication, Levetiracetam (Keppra), be reduced to 1000mg nightly for one week then discontinued. Resident #95's May 2023 Medication Administration Record (MAR) indicated the Levetiracetam was not discontinued. The resident continued to receive 1000 milligrams (mg) twice daily for the remainder of May 2023. Resident #95's June MAR revealed the resident received Levetiracetam at 1000mg twice daily until June 27th when the resident refused the medication. An interview was conducted with Nurse #6 on 7/19/2023 at 12:40PM. He stated he did not work	F 757	newly hired certified nursing assistants as well as newly contracted agency nurses and certified nursing assistants. 4) Nursing leadership to audit all After Visit Summaries from external provider visits for the next 4 weeks, and then randomly thereafter to ensure that all recommendations/orders are carried out timely. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. The Director of Nursing will be responsible for this plan. 5) Date of compliance 8/22/23	

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F 757	Continued From page 50	F 757		

the date the resident returned from the neurologist, 5/4/2023. Nurse #6 further stated Resident #95 did tell him the levetiracetam had been discontinued by the neurologist but not until 6/27/2023. He did not recall the resident mentioning it prior to that date.

On 7/19/2023 at 12:50 an interview was conducted with the Medical Records Coordinator. She reviewed the resident's medical records and stated Resident #95 did have an after-visit summary from the neurologist dated 5/4/2023. She further stated the summary was uploaded into the resident's medical record on 5/16/2023. She did not recall how she obtained a copy of the after-visit summary. Typically, the resident will bring a copy back from the appointment and give it to one of the nurses. The nurse will then give her a copy to upload into the medical record. If the resident does not return with a copy of the visit summary, she could obtain the visit via going online or call the physician's office and request a summary be faxed to her.

An interview was conducted with the Medical Director on 7/19/2023 at 1:22PM. He stated he did not recall being notified of the neurology after-visit summary recommendations. When he was made aware, he discontinued the levetiracetam. It is his expectation that staff review the after-visit summary and make him aware of any new orders or recommendations.

The Director of Nursing (DON) was interviewed on 7/19/2023 at 1:30PM and stated when a resident returns from an appointment, they return with an after-visit summary that should be given to the nurses to review. If there are any new orders, the nurse should relay them to the

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F 757	Continued From page 51 Medical Director or the Nurse Practitioner. Then, the summary should be given to Medical Records to upload into the resident's medical record. That did not happen with Resident #95. It was unclear where the process failed.	F 757		
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. §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 date sliced fruit stored inside the reach in refrigerator and the Dietary Manager (DM) and dietary aide #1 failed to wear hair coverings for 2 of 5 staff working in the kitchen. These practices had the potential to affect food served to residents. The findings included:	F 812	F812 Food Procurement, Store/Prepare-Serve-Sanitary The Dietary Manager discarded the peaches and carrots on 7/16/23 and the staff members without hair coverings were addressed at the time of identification. 2. The Dietary Manager conducted	8/22/23

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F 812	Continued From page 52 During a kitchen tour on 7/16/23 at 11:20 AM with the DM there was observed in the reach in refrigerator sliced peaches in a metal container with clear wrap covering it. There was no date observed. The DM stated they were to be served at lunch today and that was why they were inside the reach in cooler. He stated they should have been labeled. In the cooler, there was observed a metal container of sliced carrots covered with clear wrap on a metal rack stored underneath a metal pan with a cooked pork roast covered with clear wrap. The DM stated the vegetable should be stored above the meat. The DM's head appeared clean shaven and absent of a hair covering during the tour. He stated he forgot his hat in the car and should be wearing it. During a lunch meal preparation observation on 7/18/23 at 11:55 AM, dietary aide #1 who had short, twisted hair was observed in the meal area not wearing a hair covering. She stated she forgot to put on a hair covering and that she would get one immediately. The DM was also present in the meal area and made no comment. An interview was completed on 7/20/23 at 12:04 PM with the interim Administrator. He stated food should be dated when made, no vegetables should be stored underneath meat and all dietary staff should be wearing hair coverings in the kitchen.	F 812	observation of staff to determine that all staff were wearing appropriate hair coverings; no issues were identified on 8/14/23. On 8/14/23, The Dietary Manager conducted an audit of all food storage areas to ensure all opened items were properly labeled, dated and stored. Any identified concerns were immediately corrected. 3. The Dietary Regional Manager conducted re-education with the dietary manager and dietary staff regarding proper use of hair coverings and policy/practice regarding food storage to include labeling and dating of open food/beverage items. Dietary Manger/Designee will also be providing the education for newly hired employees to include dietary staff, activities staff, nurses, newly hired certified nursing assistants as well as newly contracted agency nurses and certified nursing assistants. 4. The Dietary Manager/designee will complete audits at least 5 times per week to monitor proper use of hair coverings as well as proper storage, labeling and dating of opened food items. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. The Administrator will be responsible for	

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F 812	Continued From page 53	F 812	this plan. 5. Date of compliance 8/22/23	
F 867 SS=E	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 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,	F 867		8/22/23

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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 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

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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 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 reviews, observations, resident,

F 867 Quality Assurance

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F 867	Continued From page 56 and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey conducted on 03/17/22 and during a complaint investigation on 6/12/23. This was for 4 deficiencies that were cited in the areas of Safe/Clean/Comfortable/Homelike Environment, Care Plan Timing and Revision, Free of Accident Hazards/Supervision/Devices, Food Procurement, Store/Prepare/Serve-Sanitary, which were previously cited on 03/17/22, and Free of Accident Hazards/Supervision/Devices was cited on 06/12/23. All 4 of these deficient practice areas were recited on the current recertification, follow up, and complaint survey of 8/2/23. The duplicate citations during three federal surveys of record shows a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1) F584-Based on observations and staff interviews, the facility failed to 1) replace 2 bed side commodes with visible rust on the legs and frame for 2 of 6 resident bathrooms and 2) failed to repair or replace broken Packaged Terminal Air Conditioner (PTAC) air filters for 1 out of 12 resident rooms reviewed for comfortable, clean, and homelike environment. During the facility's recertification survey of 03/17/22, the facility failed to ensure resident rooms and a resident bed were in good repair. In addition, the facility failed to ensure a resident's	F 867	1) Facility received repeat citation of F 584, F 657, F 689, and F 812 during recertification, revisit and complaint survey which had been cited on prior surveys. Revised plans have been developed to address Safe/Clean/Comfortable/Homelike Environment, Care Plan Timing and Revision, Accidents Hazards/Supervision/Devices, and Food Procurement, Store/Prepare/Serve-Sanitary with ongoing monitoring by the Quality Assurance and Performance Improvement Committee. 2) All residents have the potential to be affected. Root Cause Analysis completed by the Interdisciplinary Quality Assurance Team for F 584 Safe/Clean/Comfortable/Homelike Environment, F 657 Care Plan Timing and Revision, F 689 Accidents Hazards/Supervision/Devices, and F812 Food Procurement, Store/Prepare/Serve-Sanitary to determine the systemic break that led to the deficient practices with revised plans to address. 3) Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Senior Administrator on 8/15/23. (QAPI Team consists of: Administrator, Director of Nursing, Dining Director, Business Office Director, Human Resource Manager, Maintenance Director, Social	

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F 867	Continued From page 57 bathroom, resident wheelchairs, and dining room were clean and sanitary. This was for 11 of 11 areas reviewed for environmental concerns. 2) F657-Based on staff interviews and record review, the facility failed to revise the comprehensive care plan in the area of transfer status for 2 (Resident #106 and Resident #30) of 30 residents reviewed for care plan revision. During the facility's recertification survey of 03/17/22, the facility failed to review and revise the care plan in the area of nutrition for 1 of 29 residents reviewed. 3) F689-Based on resident, staff, Medical Director (MD) and Therapy Director interviews and record review, the facility failed to transfer a resident using a sit to stand lift (a mechanical lift that assist a resident with limited mobility in standing up from a seated position) as care planned and according to the physical therapy discharge summary (Resident #106). The facility also failed to transfer a resident requiring a total mechanical lift (portable total body lift used to minimize physical effort) for transfers resulting in a fall without injury (Resident #30). This was for 2 of 8 residents reviewed for accidents. During a complaint investigation on 6/12/23, the facility failed to effectively monitor a resident who had a history of noncompliance with the smoking policy, for proper storage of smoking materials including lighters for 1 of 3 sampled residents reviewed for smoking. During the facility's recertification survey of 03/17/22, the facility failed to prevent a resident from falling out of bed during a bed bath when	F 867	Services Director, Housekeeping/Laundry Manager, Nursing Supervisors, Activities Director, Infection Preventionist, Medical Director and Therapy Director). Education included review of Quality Assurance and recognizing areas for Performance Improvement, Root Cause Analysis and monitoring of Plans for improvement. Any QAPI members not available at the 8/15/23 training will be trained by the Administrator on or before 8/18/23. 4) The Administrator to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The QAPI Committee to review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. Regional Nurse to review all monthly QAPI Minutes x 6 months and attend QAPI Meetings Quarterly to ensure that the Committee is maintaining implemented procedures/interventions to prevent recurring non-compliance. The Administrator will be responsible for implementation of the plan. 5. Date of Compliance: August 22, 2023	

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one staff provided assistance for a resident who was dependent on two staff for bathing. The facility also failed to thoroughly investigate and analyze falls to determine causative factors and implement appropriate interventions to reduce the risk for further falls. This was for 2 of 9 residents reviewed for accidents.

4) F812-Based on observations and staff interviews, the facility failed to date sliced fruit stored inside the reach in refrigerator and staff failed to wear hair coverings when working in the kitchen. These practices had the potential to affect food served to residents.

During the facility's recertification survey of 03/17/22, the facility failed to label, and date opened food items in 1 of 2 nourishment refrigerators reviewed for food storage.

An interview was conducted with the administrator and Senior Administrator on 07/20/23 at 11:31 AM. The Senior Administrator stated she felt the repeat citations were due to the facility's management turnover. She indicated the facility's Administrator retired June 2022, and she was only standing in temporarily and they have recently hired a new administrator that will be starting 09/01/2023.