STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING ______ B. WING ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		10/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/17/2023

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

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to update names and contact information of staff, develop and maintain the EP training and testing program, provide annual education for the emergency training program, and failed to test the emergency plan at least annually. The findings included: A review of the facility's Emergency Preparedness (EP) plan was conducted on 9/27/23 and revealed the following: a) The EP plan did not include current names and contact information for staff which included updated ownership, Director of Nursing, Social Worker, Staff Development Coordinator, Business Office Manager, Medical Records Clerk, and volunteers. b) The EP plan revealed the facility did not develop and maintain the EP training and testing based on a facility risk assessment. c) The EP plan revealed no documentation regarding annual education to staff, or providers. d) The EP plan revealed no documentation regarding annual testing exercises, activation of EP plan, or community-based exercises. The last	E 001	E-001 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 10/12/2023 the Administrator updated the Emergency Preparedness plan to include current names and contact information for the Ownership, Director of Nursing, Social Worker, Staff Development Coordinator, Business Office Manager, Medical Records Clerk, and any Volunteers. On 10/12/2023 the Administrator developed training and testing material based on the facility's risk assessment and initiated training /education to the staff and providers. Documentation to be retained for record keeping. On 10/12/2023 the Administrator initiated annual education of the Emergency Preparedness plan to staff and providers that include testing exercises, activation of the Emergency preparedness plan, and	

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E 001	Continued From page 2 documented EP tabletop exercise was completed in April 2022. An interview was completed on 9/27/23 at 1:05 pm with the Regional Director of Clinical Services and Operations currently acting Interim Director of Nursing (DON) stated the Administrator was responsible for the facility's EP plan. A telephone interview was conducted on 9/27/23 at 1:15 pm with the Administrator who revealed the EP plan had not been updated since the change of ownership and new management positions on July 5, 2023. He reported the facility had annual EP education binders with staff signatures but stated he was unable to locate the binders. The Administrator stated the previous owner made the decision to wait for change of ownership and allow for new owners to determine the facility risk assessment, EP training and testing plan, and to complete the annual EP testing. The Administrator confirmed that no annual EP testing, activation of EP plan, or community-based training had been completed since April 2022. As of the survey exit on 9/27/23, the facility was unable to provide any documentation regarding updated staff contacts, EP training and testing plan based on the facility risk assessment, documentation of annual EP training for staff, or required annual testing exercises.	E 001	community-based exercises. Documentation to be retained for record keeping. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 10/12/2023 the Regional Director of Clinical Services and Operations re-educated the Administrator regarding the requirements on maintaining a comprehensive Emergency Preparedness Plan. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Monitoring will be done by the Administrator or designee to monitor and ensure that through observation and review, a comprehensive Emergency Preparedness Plan is maintained. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. The Administrator or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 3 An unannounced recertification and complaint investigation survey was conducted on 9/24/2023 through 9/27/2023. Event ID# HVCX11. The following intakes were investigated NC00205937, NC00205161, NC00205374, NC00204167 and NC00202742. 7 of 18 complaint allegations resulted in a deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-	F 553		10/12/23

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F 553	Continued From page 4 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to invite the resident to participate in the development of care planning for 1 of 14 Residents care plans reviewed (Resident #41). The findings included: Resident #41 was admitted to the facility on 4/6/2023, and recently readmitted on 7/13/2023 with diagnoses that included Anemia, Type 2 Diabetes Mellitus, Chronic Kidney disease and Hyperlipidemia. A review of Resident #41's most recent Quarterly Minimum Data Set (MDS) assessment dated 7/19/2023 revealed she was cognitively intact. A review of Resident #41's care plan revealed it was updated on 7/23/2023. A review of Resident #41's nursing progress notes revealed there was a care plan meeting on 4/13/23 and 7/19/23. There was no documentation to indicate Resident # 41 was included in her care plan development and/or invited to participate in her care plan meeting. During an interview with Resident #41 on	F 553	F-553 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrective action will be accomplished for resident(s) found to be affected: Resident #41 was invited and attended a care plan meeting on 10/12, 2023. How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed: On 10/10/23, an audit was completed by the MDS nurse on all residents for the last quarter (July-Sept), to ensure that the residents attended the care plan meeting.	

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Continued From page 5

9/24/2023 at 12:00 P.M. Resident #41 stated she has not participated in any care plan meeting since her admission to the facility. She revealed she never received a verbal or written invitation. She explained further she would be readily available to attend any meeting when invited.

An interview on 9/25/2023 at 10:19A.M. with the MDS Nurse revealed she was not sure why she did not involve or invite Resident #41 to her care plan meeting. She stated it was her responsibility to invite Resident #41 to her care plan meeting.

An interview was conducted with the Director of Nursing (DON) on 9/26/2023 at 10:58 A.M. She stated it was the responsibility of the MDS nurse to invite Resident #41 to the care plan meeting. During an interview with the Administrator on 9/27/2023 at 1:28 P.M. he stated the MDS Nurse had the responsibility of inviting Resident #41 to the care plan meeting. He stated he was not aware Resident #41 never participated in her care plan meeting.

F 553

Any care plan meeting that were not conducted with the resident present were immediately re-scheduled by the MDS nurse and the care plan meetings were completed by 10/12/23.

What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 10/11/23, the Administrator re-educated the MDS nurse regarding the requirement that all residents and (or) their responsible party are invited to participate in the care planning process.

Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:

Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that all residents and (or) their responsible party are invited to participate in the care planning process. The monitoring process will include a weekly MDS care planning schedule. This monitoring will be weekly for 4 weeks then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can

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F 553	Continued From page 6	F 553	modify this plan to ensure the facility remains in substantial compliance.	
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility	F 576		10/14/23

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F 576	Continued From page 7 (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to provide mail delivery to the residents on Saturdays. This had the potential to affect all 45 of 45 residents residing in the facility. The findings included: An interview with members of the Resident Council on 9/26/23 at 11:22 am revealed the facility did not deliver any mail on Saturdays. The members present for the meeting were Resident #41, Resident #28, Resident #11, Resident #35, Resident #6, and Resident #2. The Resident Council members stated the mail was only delivered during the week by the Activities Director and they had to wait until Monday to have Saturday's mail delivered. An interview was conducted with the Activities Director on 9/26/23 at 11:40 am who revealed she did not collect or hand out mail to residents on Saturday because she did not work on the weekend. The Activities Director stated when she returned to work on Monday, she would pass out Saturday's mail to the residents. During an interview on 9/27/23 at 1:11 pm with the Administrator he revealed the Activities Director delivered resident mail Monday through Friday and he was aware the mail was not delivered to the residents on Saturdays. He stated he wanted to make sure the mail was	F 576	F- 576 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrective action will be accomplished for resident(s) found to be affected: The mail will be delivered to the residents six days a week. How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents.	

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F 576	Continued From page 8 delivered to the residents properly, so he thought it was best to wait for the Activities Director to return on Monday and deliver Saturday's mail to the residents.	F 576	What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: The Administrator has the Facilities Services person delivering the residents mail on Saturdays starting on 10/14/23. The residents were notified of the Saturday mail delivery change formally at a Resident Council meeting on 10/18/23. The Activity Director visited the residents that could not attend the meeting to notify of this change. Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained: Monitoring will be done by the Administrator or designee to monitor and ensure that the mail delivery service is occurring every Saturday. A resident council meeting will be held monthly and the monitoring process will take place weekly for 3 months. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		10/10/23

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F 677

Continued From page 9

CFR(s): 483.24(a)(2)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews, the facility failed to provide nail care to 1 of 3 dependent residents reviewed for activities of daily living (ADL) (Resident #27).

The findings included:

Resident #27 was admitted to the facility on 4/12/18 with diagnoses which included stroke with hemiplegia (paralysis one side of body) on the right side and dementia.

The Minimum Data Set (MDS) quarterly assessment dated 9/07/23 revealed Resident #27 had severe cognitive impairment and required staff assistance for personal hygiene and bathing. Resident #27 was not coded for behaviors and had impaired range of motion on one side for the upper and lower extremities.

Resident #27's care plan, last revised on 9/09/23, revealed he had an activities of daily living (ADL) self-care performance deficit related to history of stroke with hemiplegia and was dependent on staff for personal care and bathing.

Review of Resident #27's care guide (no date) revealed he was scheduled for showers on Monday and Thursday on the 3:00 pm-11:00 pm shift.

F 677

F-677

This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

How corrective action will be accomplished for resident(s) found to be affected:
Resident #27 was provided nail care on 9/26/23.

How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to

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F 677 Continued From page 10

Record review of the Resident #27's shower documentation by Nurse Aide (NA) #2 revealed his shower was documented as not applicable (NA) on 9/25/23 on the 3:00 pm-11:00 pm shift. No further documentation regarding why the shower was not completed for Resident #27.

An attempt to interview NA #2 on 9/27/23 at 8:41 am, who was assigned to Resident #27 on the 3:00 pm-11:00 pm shift on 9/25/23 (a scheduled shower day) was unsuccessful.

An observation on 9/24/23 at 11:12 am of Resident #27 revealed the fingernails of his left hand were trimmed and there was a dark brown substance under all of his nails.

A telephone interview was conducted on 9/26/23 at 2:27 pm with Nurse Aide (NA) #3 who was assigned to Resident #27 on 9/24/23 during the 7:00 am-3:00 pm. NA #3 stated she usually tried to do nail care when she gave a bed bath, but she did not give Resident #27 a bed bath or provide nail care when she was assigned to his care on 9/24/23. NA #3 stated the facility was short one NA and everyone was helping provide care to all the residents, so she just did not have enough time to check if Resident #27's fingernails were dirty.

An observation was conducted on 9/25/23 at 12:46 pm of Resident #27 revealed the fingernails of his left hand were trimmed and there was a dark brown substance under all of his nails.

An interview was conducted on 9/25/23 at 2:56 pm with NA #1 who confirmed she was assigned to provide care to Resident #27 on 9/25/23 during the 7:00 am -3:00 pm shift. She stated nail care

F 677

prevent any risk of affecting the residents.

What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 10/10/23, the Nurse Manager provided an in-service to the CNAs that nail care needs to be done daily as part of the morning care. In-service was provided to the nurses by the Nurse Manager to have oversight and observe if the residents are receiving nail care each day.

Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:
Monitoring will be done by the Director of Nursing or designee to monitor and ensure that the daily nail care is being provided to the residents each day and as needed. The monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 was completed as needed and on scheduled shower days. NA #1 reported she provided nail care if she had time if not it would be done on his shower day which was Monday and Thursday on the 3:00 pm to 11:00 pm shift. NA #1 stated she gave Resident #27 a bed bath in the morning, but she did not provide nail care on her shift because she did not have enough time to check Resident #27's nails today to see if nail care was needed. An observation on 9/26/23 at 8:29 am of Resident #27 revealed the fingernails of his left hand were trimmed and there was a dark brown substance under all of his nails. An interview was conducted on 9/26/23 at 3:23 pm with the Nurse Manager who revealed Resident #27's nail care was to be completed daily during ADL care and as needed when nails were observed to be dirty. During an interview with the Interim Director of Nursing on 9/27/23 at 12:33 pm she reported that Resident #27's nail care was to be completed daily if they were dirty.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		10/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING ______ B. WING ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	**2275 RUIN CREEK ROAD** **HENDERSON, NC 27537**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 Based on record review, observations, staff, and Physician interview, the facility failed to safely transfer a dependent resident from wheelchair to bed which resulted in the fracture of the right humeral head (shoulder joint) and injury to the toenail of the right great toe with bleeding for 1 of 1 Residents (Resident #27) reviewed for accidents The findings included: Resident #27 was admitted to the facility on 4/12/18 with diagnoses that included a history of a stroke that resulted in right sided weakness. A Quarterly Minimum Data Set (MDS) assessment dated 4/8/23 revealed that Resident #27 was severely cognitively impaired. The MDS indicated the Resident was dependent on 2 staff members for transfers and was coded as having impairment on 1 side of his upper and lower extremities. A care plan for an activities of daily living (adl) self-care performance deficit was last revised on 3/21/23. The interventions included assistance from 2 staff members and a mechanical lift for transfers, extensive to total assistance from 1-2 staff members for bed mobility, and extensive to total assistance from 1 staff member for dressing. A Care Guide dated 3/21/23 revealed Resident #27 required a 2 staff member mechanical lift transfer. A review of Resident #27's incident report dated 5/16/23 Nurse #5 revealed during a transfer from his wheelchair to his bed, Resident #27's right great toe was injured during a transfer. The report	F 689	F- 689 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrective action will be accomplished for resident(s) found to be affected: Resident #27 care plan was updated and CNA cardex in place reading 2-person transfer. How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents. What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:	

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SENIOR CITIZENS HOME	**2275 RUIN CREEK ROAD HENDERSON, NC 27537**

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F 689 Continued From page 13

revealed blood was observed on his right sock around the great toe area. The Nurse Manager evaluated the area and found the Resident's right great toe toenail was injured. The area was cleaned, and treatment was provided.

A review of Resident #27's May 2023 Physician order summary revealed an order dated 2/10/23 for Norco 5-325mg (pain medication) 1 tablet by mouth twice daily.

Review of Nurse Aide (NA) #5's statement dated 5/16/23 at 3:00pm revealed at approximately 2:45pm the NA went to transfer Resident #27 into bed to provide incontinence care. Prior to the transfer, the Resident was pointing at his feet and NA #5 observed blood on his sock, removed the sock, and notified the Nurse Manager who evaluated and treated the area.

A telephone interview was completed on 9/26/23 at 12:37pm with NA #5. The NA stated around 2:00pm-2:30pm on 5/16/23 Resident #27 requested assistance back to bed. The NA stated she placed the Resident's arms around her neck, used the waistband of his pants to lift him from his wheelchair to the bed, placed his legs in the bed, and adjusted him to a comfortable position. The NA stated once the Resident was in bed, she observed dried brown blood on his right sock. The NA stated the Resident must have hit his toe prior to the transfer. NA #5 indicated she left the room and notified the Nurse Manager. The NA stated she had worked for the facility via a staffing agency approximately one month prior to providing care for Resident #27. She indicated she was not made aware of where or how to look for a resident's care plan and did not ask another staff member how to access it. NA #5 confirmed

F 689

On 10/2/23 the Nurse Manager in-serviced the CNAs on the Hoyer lift transfer policy, Hoyer Lift proper use and re-education to review the CNAs cardex for proper care of the resident prior to rendering care.

Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained: Monitoring will be done by the Director of Nursing and Nurse Manager to monitor and ensure that the CNAs are using the Hoyer lift appropriately. In-service of the Hoyer lift provided to the CNAs by the Nurse Manager. The monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

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F 689	Continued From page 14 she was aware Resident #27 was a 2 staff member mechanical lift transfer. The NA stated she did not request assistance from an additional staff member to transfer Resident #27 or use the mechanical lift. Review of the Activity Assistant's written statement dated 5/18/23 at 2:00pm revealed at approximately 2:30pm (5/16/23) she observed NA #5 exiting Resident #27's room. The NA informed the Activity Assistant the Resident's toenail was bleeding. The Activity Assistant entered the Resident's room, observed him in bed, and the toenail on his right foot bleeding. The statement further revealed she did not observe a mechanical lift in the room or located outside the Resident's room. Review of Nurse #3's written statement dated 5/16/23 revealed at approximately 2:45pm the Nurse Manager notified her Resident #27's toenail was bleeding. The statement revealed the evening shift nurse had arrived on shift and completed the incident report. An interview was completed on 9/26/23 at 11:44am with Nurse #3. The Nurse verified she was assigned to provide care for Resident #27 on 5/16/23. Nurse #3 stated she was completing shift report to the oncoming nurse when she was notified by the Nurse Manager that the Resident had an injury to his right great toe. The Nurse stated the oncoming nurse completed the Incident Report regarding the injury. An interview was completed on 9/26/23 at 11:55am with NA #7. The NA stated she was assigned to provide care for Resident #27 on 5/17/23. NA #7 revealed during the Resident's	F 689		

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F 689 Continued From page 15 F 689

bath, he was holding his right arm and did not want her touching it during his bath. The NA stated she informed Nurse #3 and the Nurse Manager. The NA confirmed the Resident's care plan which revealed what type of assistance and how the Resident transferred was attached to the back of the closet door. She stated when she was unsure of what extent of care a resident was, she referred to the care plan.

An interview was completed on 9/26/23 at 11:50am with Nurse #4. The Nurse revealed she was assigned to care for Resident #27 on 5/17/23. Nurse #4 stated the NA assigned to care for Resident #27 (NA #7) on 5/17/23, notified the Nurse Manager at some point during the morning (was unable to recall the time), that the Resident was experiencing right arm pain. The Nurse stated the Physician evaluated the Resident and ordered him to be transferred to the emergency department for evaluation and treatment.

A progress note written by the Nurse Manager and dated 5/17/23 at 11:15am stated the Physician was in the facility that morning, was made aware Resident #27 complained of pain in his right arm and shoulder, the Physician evaluated the Resident, and placed an order to send him to the emergency department for an x-ray and treatment.

An interview was completed on 9/26/23 at 9:37am with the Nurse Manager. The Nurse Manager stated upon entering the Resident's room on 5/16/23, she observed bright red blood around Resident 27's right great toenail. The Nurse indicated she provided treatment to Resident #27's right great toe on 5/16/23 following an injury that occurred during a transfer

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F 689	Continued From page 16	F 689		

by NA #5. She stated at that time the Resident did not complain of pain in his right arm. The Nurse stated Resident #27 had required 2 staff members and a mechanical lift transfer since admission to the facility due to right sided weakness resulting from a stroke. The Nurse Manager stated it was the facility's protocol to have 2 staff members assist with mechanical lift transfers. The Nurse revealed she observed Resident #27 holding his right arm and grimacing when he touched it.

Review of NA #6's written statement dated 5/18/23 at 3:50pm revealed she provided care for Resident #27 on the night of 5/16/23 and he did not complain of pain while care was provided.

Multiple attempts made to contact NA #6 were unsuccessful.

Review of Nurse #3's second written statement dated 5/18/23 revealed a nursing assistant notified her Resident #27 complained of pain in his right arm on 5/17/23. Nurse #3 stated she observed the Resident unable to move his arm without experiencing pain. The Physician was present in the facility and informed of what occurred during the Resident's transfer into bed on 5/16/23. The Physician evaluated the Resident, and an x-ray of his arm was ordered. An interview was completed on 9/26/23 at 11:44am with Nurse #3. Nurse #3 revealed she provided care for Resident #27 on 5/17/23 also. The Nurse stated she was notified by NA #7 the Resident was holding his right arm and refused for her to wash it during his bath. Nurse #3 stated the Nurse Manager and herself verified the Resident had pain in his right arm and notified the Physician.

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F 689	Continued From page 17	F 689		

Review of Resident #27's hospital discharge summary dated 5/17/23 revealed the Resident was diagnosed with a fracture of the right humeral head. The fracture was treated with the application of a sling while awake and until the Orthopedic (bone) Physician discontinued the order.

A progress note dated 5/17/23 at 10:32pm stated the Resident returned to the facility at approximately 5:40pm with a diagnosis of a right humeral head fracture. The Resident had no complaints of pain or discomfort.

A Report of Consultation note revealed Resident #27 was evaluated by an Orthopedist on 5/19/23. The note revealed there was no right arm swelling or redness observed during the visit. The Physician ordered Resident #27's right arm to remain in a sling for approximately 4 weeks and Norco 5-325mg (pain medication) 1 tablet every 6 hours as needed for pain.

A physician's order dated 5/21/23 indicated Resident #27's Norco 3-325mg twice daily was increased to three times daily.

A telephone interview was completed on 9/25/23 at 10:58am with the facility's Administrator. The Administrator revealed on 5/16/23 at approximately 2:30pm NA #5 transferred Resident #27 into bed without the assistance of a 2nd staff member and mechanical lift as the care plan indicated. Following the transfer, NA #5 notified the Nurse Manager she observed blood on the Resident's right sock. The Nurse Manager evaluated and provided treatment to the Resident's injured great right toe. The

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F 689	Continued From page 18	F 689		

Administrator stated at that time Resident #27 did not complain of right arm pain. During the morning of 5/17/23 it was noted the Resident complained of right arm pain and was sent to the emergency department for evaluation and treatment. During the visit, the Resident was found to have a right arm fracture and was discharged with an order to wear a right arm sling and follow up with an Orthopedist. The Administrator stated NA #5 was removed from the schedule immediately and an investigation was started. The Administrator stated the investigation revealed NA #5 transferred Resident #27 by lifting him from his chair and pivoting him to the bed. He revealed Resident #27 was unable to stand due to right sided deficits due to a stroke and was a 2 staff member mechanical lift transfer. The Administrator revealed during his interview with NA #5, the NA confirmed she was aware Resident #27 was a 2 staff member mechanical lift transfer and completed the transfer by herself. The Administrator stated education on proper transfers of a resident was started on 5/16/23 by the DON and was provided to all nursing staff.

An observation of Resident #27 was completed on 9/25/23 at 11:16am. The Resident was sitting up in his wheelchair, when questioned if he had pain in his right arm his shook his head no.

An interview was completed on 9/26/23 at 9:20am with the Medical Director. The Medical Director revealed she evaluated Resident #27 on 5/17/23 due to his complaints of right arm pain and injury to his right great toe. The Medical Director indicated she ordered Resident #27 to be transferred to the hospital for an evaluation and treatment. She stated due to the Resident's

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F 689	Continued From page 19 multiple health diagnoses (iron deficiency anemia, seizure disorder, and Multiple Sclerosis) and anticonvulsant medications; he was at a higher risk for bone fractures. The Medical Director stated Resident #27 had limited range of motion (ROM) in right side due to a previous stroke and a 2 staff member mechanical lift transfer was appropriate. She stated the right humeral head fracture did not decrease the Resident's ROM and placing a sling on the Resident's right arm and Orthopedist follow up visits were appropriate treatment. The Medical Director indicated she reviewed the 5/19/23 Orthopedist consult report and scheduled Resident #27's pain medication because she felt due to his dementia, he would not request medication when he was in pain. The Medical Director stated it was her opinion the fracture was a result of the improper transfer on 5/16/23. She revealed due to the Resident's dementia, it was possible the Resident focused on the injury of his toe on 5/16/23 and was unaware of right arm pain until later. A telephone interview was completed on 9/26/23 at 1:15pm with the Former Director of Nursing (DON) #2. The DON stated all staffing agency employees were educated on where care plans were in a resident's room and how to access it in the resident's electronic medical record. The DON revealed when she interviewed NA #5 regarding the 5/16/23 transfer, the NA verified she was aware Resident #27 was a 2 staff member mechanical lift transfer, did not want to wait for an additional staff member to assist with the transfer, and felt comfortable transferring the Resident the way she completed it. The DON stated Resident #27 complained of	F 689		

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F 689	Continued From page 20 right great toe pain on 5/16/23 and on the morning of 5/17/23 complained of right arm pain. A follow-up telephone interview was completed on 9/27/23 at 1:20pm with the Administrator. The Administrator stated it was his expectation all nursing staff refer to a resident's care plan when they were unsure of a resident's level of care.	F 689		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to have a Registered Nurse (RN) for at least eight consecutive hours a day, 7 days week for 8 of 62 days reviewed (7/15/23, 7/16/23, 7/22/23, 7/23/23, 7/29/23, 7/30/23, 8/6/23 and 8/13/23). Findings include: The nursing staff schedule and the staff posting was reviewed from 5/1/223 through 9/15/23. The	F 727	F- 727 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan	9/28/23

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daily staffing sheet indicated a Registered Nurse (RN) was not scheduled for at least eight consecutive hours a day on the following dates: 7/15/23, 7/16/23, 7/22/23, 7/23/23, 7/29/23, 7/30/23, 8/6/23 and 8/13/23.

In an interview with the Nurse Manager (NM) on 9/25/23 at 8:37 A.M. she stated she was the scheduler for the facility. She revealed the staffing agency was contracted by her facility to assign an RN to the facility on 7/15/23, 7/16/23, 7/22/23, 7/23/23, 7/29/23, 7/30/23, 8/6/23 and 8/13/23 but failed to do so.

During an interview with the prior DON on 9/25/2023 2:33 P.M. she stated she was the RN on weekdays. She revealed they relied on an agency for weekend RN coverage, and the agency was unable to provide RN coverage on 7/15/23, 7/16/23, 7/22/23, 7/23/23, 7/29/23, 7/30/23, 8/6/23 and 8/13/23.

An interview was conducted on 9/25/23 at 8:37 A.M. with the Director of Nursing (DON). She revealed she was aware of no RN coverage on 7/15/23, 7/16/23, 7/22/23, 7/23/23, 7/29/23, 7/30/23, 8/6/23 and 8/13/23. She stated they have had difficulty hiring RN's and the agency was not able to provide an RN to assist with the coverage on those dates.

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of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

How corrective action will be accomplished for resident(s) found to be affected:
No residents were affected.

How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents.

What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 9/28/23 the Regional Nurse Consultant, educated the new nurse manger regarding the daily Registered Nurse staffing requirements that require at least 8 hours of RN coverage per day, 7 days a week and is to also have specific responsibilities designated by the facility that may include staff supervision, emergency coordinator, physician liaison, as well as direct resident care. RN staff that do not meet the above criteria will not be counted.

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F 727	Continued From page 22	F 727	Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained: Monitoring of the daily staffing sheets will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that the required RN staffing requirements are met. This monitoring process will take place daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		9/27/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews the facility failed to post nurse staffing in a location that was readily accessible to residents and visitors on 3 of 4 days during the survey (9/24/23, 9/25/23, and 9/26/23).

The findings included:

An observation on 9/24/23 at 9:30 am revealed the daily nurse staff posting was hung on the wall behind the nursing station, which was accessible for staff only. The daily nurse staffing sheet was a white, 8 X 10-inch piece of paper with both

F 732

F- 732

This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under

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sides of the posting curled toward the center of the paper. The daily nurse staff posting was not visible or accessible for residents or visitors to view.

Additional observations on 9/25/23 at 12:15 pm, and 9/26/23 at 1:05 pm of the facility's daily nurse staff posting revealed it was hung on the back wall behind the nursing station, which was restricted for staff only per the signage. The daily nurse staffing sheet was a white, 8 x 10-inch piece of paper and was not visible or accessible for residents or visitors to view.

An interview was conducted on 9/26/23 at 2:33 pm with the Interim Director of Nursing who revealed the Nurse Manager was responsible for posting the facility's daily nurse staff posting.

An interview was completed on 9/26/23 at 3:25pm with the Nurse Manager who revealed she was new to the position, and she was never instructed where to place the facility's daily nurse staff posting. She stated she was not aware the daily nurse staff posting had to be visible to residents and visitors.

A telephone interview was conducted on 9/27/23 at 1:11 pm with the Administrator who revealed the facility's daily staff posting was to be placed in an area that was visible for residents and visitors to view, but he was not aware it was placed behind the nursing station.

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state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

How corrective action will be accomplished for resident(s) found to be affected:
No residents were affected.

How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents.

What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 9/27/23 the Regional Nurse Consultant, educated the new nurse manger on the daily posting information requirements that it needs to be posted in a prominent area and easily visible and accessible to both the residents and visitors.

Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:
Monitoring will be done by the Administrator or designee to monitor and ensure that the posted nursing staff information is in a prominent location,

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F 732	Continued From page 25	F 732	easily visible an accessible to both residents and visitors. The monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		10/16/23

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F 758	Continued From page 26 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, Physician interview, and Pharmacy Consultant interview, the facility failed to ensure Physician's orders for PRN (as needed) psychotropic medications were time limited in duration for 1 of 7 Residents (Resident #24) reviewed for unnecessary medications. The findings included:	F 758	F- 758 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the	

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F 758	Continued From page 27 Resident #24 was admitted to the facility on 8/10/23 with diagnoses that included Lewy Body dementia, anxiety disorder, and diabetes. The Admission Minimum Data Set (MDS) assessment dated 8/10/23 revealed the Resident was cognitively impaired. She was coded as not having any behaviors during the assessment period. A Physician order dated 8/10/23 indicated Lorazepam 0.5 milligrams (mg) 1 tab by mouth every 12 hours as needed (PRN) was ordered without a stop date. The Note to Attending Physician/Prescriber dated 8/15/23 revealed the facility was notified by the Pharmacy Consultant that Resident #24's PRN lorazepam medication did not have a stop date. A care plan was last revised on 8/20/23 for impaired cognitive function related to dementia. Interventions included administering medications as ordered, cue, reorient, and supervise as needed, and present one thought, idea, or question at a time. Review of Resident #24's August 2023 and September 2023 Medication Administration Report revealed the Resident had not received any doses of the medication. An interview was completed on 9/26/23 at 9:40am with the facility's Nurse Manager. The Nurse stated she was aware PRN psychotropic medications required a stop date and was unsure why Resident #24's PRN medication did have a stop date.	F 758	correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrective action will be accomplished for resident(s) found to be affected: No residents were affected. How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed: An audit (titled: f-758) was completed on 10/16/23 by the nurse manager to ensure that all residents on PRN psychotropic medications had a 14 day stop order. The audit revealed there were no additional residents. What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 10/16/23 the Regional Nurse and Nurse Manager initiated a re-education the nursing staff that all PRN Psychotropic medications require a 14 day stop date. Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:	

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F 758	Continued From page 28 An interview was completed on 9/27/23 at 9:52am with the Pharmacy Consultant. He indicated PRN psychotropic medications required an initial 14 day stop date. The Pharmacy Consultant revealed the Physician then reevaluated the Resident for continued use of the medication and documented the rationale for extending the medication. An interview was completed on 9/27/23 at 10:52am with the facility's Medical Director. She stated when she prescribed a PRN psychotropic medication, it was ordered with an initial stop date. The Physician revealed she then revaluated the resident and if required, extended the medication for a period she felt appropriate. An interview was completed on 9/27/23 at 12:59pm with the facility's Interim Director of Nursing. The DON stated she was aware that all PRN psychotropics required a stop date and was unaware why a stop date had not been included in the medication order. The DON revealed she felt the recent staff turnover resulted in the failure to follow through with following through on notification of a stop date required for the medication.	F 758	The Director of Nursing or designee will monitor all new orders for PRN Psychotropic medications to have a 14 day stop date. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		9/28/23

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F 761	Continued From page 29 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure 1 of 1 wound treatment carts and 1 of 2 medication carts (Hall 2) were not secured while unattended. The findings included: 1. A continuous observation on 9/25/23 at 8:22 am through 8:38 am of the wound treatment cart revealed the cart was unlocked with the lock in the outward position and the key hanging from the lock. The wound treatment cart was located outside room 22, without staff present. At 8:38 am the Infection Preventionist (IP) came from another hall and removed the key from the cart and pushed the lock in to secure the wound treatment cart and entered Room 22. The IP and the Minimum Data Set (MDS) Nurse exited the room.	F 761	F- 761 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrective action will be	

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An interview was conducted with the MDS Nurse on 9/25/23 at 9:22 am who revealed she was told by the IP that she left the wound treatment cart unlocked with the key in the lock when she entered Room 22. The MDS Nurse stated she was trying to help with wound treatments and should have locked the cart and taken the keys with her into the room. The MDS Nurse was unable to state why she left the wound treatment cart unsecure.

An interview was conducted with the IP on 9/25/23 at 11:38 am who revealed she was notified by the Social Worker that the wound treatment cart was unlocked so she came to lock the cart. The IP stated the treatment cart had resident creams/ointments, medicated dressings, and treatment supplies. She stated the MDS Nurse was required to lock the cart and hold the keys when the wound treatment cart was unattended.

During an interview with the Interim Director of Nursing on 9/27/23 at 12:41 pm revealed the wound treatment cart was to be locked when unattended.

2. A continuous observation on 9/25/23 at 11:12 am through 11:14 am revealed the Hall 2 medication cart was outside Room 34 unlocked with the lock button in the outward position and unattended. Nurse #2 was observed to be in Room 34.

An interview was conducted with Nurse #2 on 9/25/23 at 11:14 am. She revealed she was just right in the room and forgot to lock the cart. Nurse #2 stated the medication cart was to be

F 761

accomplished for resident(s) found to be affected:
No residents were affected.

How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents.

What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 9/28/23 the Regional Nurse Consultant provided in services for the nurses and the med aides on always locking the medication cart and treatment cart when not in use. The medication and treatment cart keys must be always on your possession, never leaving the keys dangling from the medication or treatment cart.

Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:
Monitoring will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that the medication and treatment carts are locked when not in use. The monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months.

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F 761	Continued From page 31 locked when she was in Room 34. During an interview with the Interim Director of Nursing on 9/27/23 at 12:41 pm she revealed the medication cart was to be locked when unattended.	F 761	Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide pureed food items with a smooth consistency. This failure had the potential to affect 7 of 45 residents with diet orders for a pureed diet texture. The findings included: A review of the Diet Order Report dated 9/27/23 revealed 7 residents with diet orders for a pureed diet texture. Review of the menus revealed the facility followed the National Dysphagia Diet (NDD) for residents with diet orders for a pureed diet texture. The	F 805	F- 805 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.	9/27/23

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F 805	Continued From page 32 NDD recorded a dysphagia pureed diet required all foods pureed and thickened, if necessary, to a pudding-like consistency, lump free, requiring little to no chewing. An observation was conducted on 9/25/23 at 12:46 pm of Resident #27 eating his lunch meal in the dining room. Resident #27's meal ticket indicated he was on a pureed diet. The observation revealed no issues with the consistency of the pureed meal. A continuous observation of the lunch meal tray line on 9/26/23 from 11:45 AM - 12:01 PM revealed the Certified Dietary Manager (CDM) recorded the internal temperature of the food items stored on the tray line intended for the lunch meal service, including pureed green beans and pureed meat sauce, were observed with a lumpy consistency smaller than pea-sized when the food was stirred. The CDM observed the lumpy consistency but did not say anything until the surveyor intervened. Cook #1 was instructed by the CDM to use a standard blender to further puree these foods until a smooth consistency was achieved. The pureed bread was a smooth pureed consistency. An observation was conducted on 9/26/23 at 8:19 am of Resident #27 eating his breakfast meal independently in his room. Resident #27's meal ticket indicated he was on a pureed diet. The observation revealed no issues with the consistency of the pureed meal. Cook #1 was interviewed on 9/26/23 at 11:45 AM. She stated that she had been preparing the pureed foods with chunks for the last 2 months because the new owners would not purchase a	F 805	How corrective action will be accomplished for resident(s) found to be affected: No residents were affected. How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed: All residents on a puree diet have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents. What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 9/27/23 the facility purchased a large Heavy-Duty Commercial blender for the kitchen. Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained: Monitoring will be done by the Administrator to ensure that the Heavy-Duty Commercial blender is in use and operating. The monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months. Any issues during monitoring will be addressed immediately. The	

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F 805	Continued From page 33 new immersion blender. The current immersion blender was broken, and she had to use a standard blender. An interview was conducted with the District Manager on 9/26/23 at 2:52 PM. She stated if the surveyor did not intervene, the pureed green beans and meat sauce with a lumpy consistency would have been served to residents with a puree diet order. She stated that the immersion blender was broken, and a standard blender was provided as a replacement. However, a standard blender would not have been sufficient in an industrial kitchen to produce pureed foods for three meals each day. The District Manager indicated that she notified the interim Director of Nursing (DON) about the broken immersion blender. The CDM stated on 9/26/23 at 2:58 PM that she told the interim DON during the morning meeting on 9/13/23 that the immersion blender was broken. The CDM told the interim DON that the previous owners provided a standard blender. The interim DON told her that a replacement immersion blender was too expensive. The CDM indicated the standard blender provided by the previous owners stopped working on 9/24, and she had to borrow the standard mixed drinks blender from the activities department to puree food for meal service. She stated that the spaghetti noodles would have been pureed further, but if the surveyor had not intervened, she would have served the pureed meat sauce and pureed green beans with lumps. If she had an operational/appropriate blender, then the pureed foods would have been at the correct consistency.	F 805	Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 805	Continued From page 34	F 805		

The Speech Language Pathologist (SLP) was interviewed on 9/27/23 at 10:55 AM. During the interview, she stated she had worked at the facility for the last 2 weeks. She further stated she fed one resident pureed food and did not find an issue with the consistency at that time. However, if pureed foods had chunks in them, the risks would be choking, aspiration pneumonia or death. The SLP indicated that no concerns about the consistency of pureed foods were brought to her attention.

A phone interview with the Registered Dietitian (RD) occurred on 9/27/23 at 10:59 AM. The RD stated he had seen the pureed foods (spaghetti, meat sauce and green beans) on 9/26/23 lunch meal tray line as Dysphagia Advanced mechanical consistency rather than puree. He stated that he noticed puree food items with a lumpy consistency within the past month due to the broken immersion blender, and he and the CDM notified the interim DON multiple times about the broken immersion blender.

The Administrator stated in an interview on 9/27/23 at 1:26 PM that he was on Family Medical Leave Act absence since the second week of July 2023. He stated that a new immersion blender was purchased 3-6 months ago, and he was unaware that it was broken. As soon as management staff were notified of a broken immersion blender, it should have been serviced or replaced immediately. Standard blenders were used in the past for emergency purposes until the immersion blender was replaced. The standard blenders needed to blend food for longer to achieve the proper consistency of pureed foods.

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F 812	Continued From page 35	F 812		
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 observation and staff interviews, the facility failed to 1) maintain the temperature of potentially hazardous cold foods at 41 degrees Fahrenheit or below (yogurt and milk) prior to delivery 2) label/date, store, and discard perishable foods beyond the use date in one of two kitchen refrigerators and failed to 3) allow plates to air dry prior to assemblage and stacking for one of two observations. These practices had the potential to affect all residents. The findings included: 1. An observation of the lunch meal dining service occurred on 9/26/23 at 12:01 PM.	F 812	F-812 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.	10/11/23

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F 812 Continued From page 36

Perishable dairy products for the lunch meal were displayed on a meal tray adjacent to the tray line. The following temperatures were obtained at the request of the surveyor by the District Manager and these foods were ready for service:
- single serve yogurt container: 59.8 degrees Fahrenheit
- whole milk carton: 49 degrees Fahrenheit

As a result, all perishable dairy products were discarded by the District Manager and Certified Dietary Manager (CDM).

During an interview with the CDM on 9/26/23 at 2:58 PM, she revealed that if the surveyor did not intervene, the yogurt and milk would have been served at unsafe temperatures. She stated the cold dairy items should have been on ice prior to meal service and not have exceeded 41 degrees Fahrenheit.

The Administrator was interviewed on 9/27/23 at 1:26 PM. He revealed that all dairy products used for meal service should come directly from the refrigerator and placed in an ice bath to remain below 41 degrees Fahrenheit.

2. An observation of the kitchen and an interview with the CDM were conducted on 9/24/23 at 10:23 AM. The following food items were found in the refrigerator in front of the ice chest: 1 package of turkey slices not dated or sealed, 1 opened plastic bag of hot dogs dated 9/15, 1 plastic bag of cabbage not sealed and dated 9/8, chunks of ham wrapped in plastic without a date, 1 plastic container labeled beef and dated 9/17, 1 not sealed plastic bag of parmesan cheese dated 9/1, 1 plastic container of baked beans dated 9/9, 1 plastic bag of ham slices dated 9/8, 1 plastic container of greens dated 9/6, 1 plastic container

F 812

(1) How corrective action will be accomplished for resident(s) found to have been affected:
No resident were found to be affected.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
On 10/11/23 the Administrator conducted a dietary audit of the refrigerator, freezer, and the 2 nourishment refrigerators for accurate storage, dating, labeling, and proper food temperatures of perishable dairy products and the nesting of plates. Audit revealed that all food items were labeled and dated appropriately along proper temperatures and plates were not stored wet.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 10/11/2023 the Administrator re-educated the Dietary Manager including all dietary staff regarding the requirements for accurate food temperatures, storing, dating, and labeling of food items in the refrigerator, freezer, and the 2 nourishment refrigerators, food temperatures of perishable dairy items along with proper storage of cleaned plates.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:

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F 812	Continued From page 37 of diced tomatoes dated 9/12, 1 not sealed plastic bag of coleslaw dated 9/19, 1 plastic container of tuna salad dated 9/13, 1 not sealed plastic bag of sliced yellow cheese dated 9/11, 1 bag of shredded yellow cheese wrapped in plastic and not dated. The Dietary Manager stated the shelf life of prepared foods/opened containers was 7 days. She stated she normally went through the refrigerator every Monday and discarded necessary items. An interview was conducted with the Administrator on 9/26/23 at 10:59 AM, and he stated that food should be labeled, dated, and stored properly. 3. An observation of the kitchen and an interview with the CDM were conducted on 9/24/23 at 10:48 AM. Thirty-one out of fifty-eight plates were observed to be stacked wet and ready for use on a shelf underneath the tray line. The CDM stated there was not enough space in the kitchen to air dry the plates. Also, there was only one air drying cart available used for the dome lids. During an interview with the Administrator on 9/27/23 at 1:26 PM, he revealed the plates should have been air dried prior to storage for meal service.	F 812	Monitoring will be done by the Administrator, or designee to monitor and ensure that through observation, the refrigerator, freezer, and the 2 nourishment refrigerators for proper food temperatures, accurate dating, labeling, and storage of food items along with the proper food temperatures of perishable dairy items, and that plates are cleaned and stored properly. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. The Administrator or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
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	F 867		10/11/23

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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, 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,

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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 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

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F 867	Continued From page 40 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 observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation survey of 5/12/22. This was for two deficiencies cited in the areas of food procurement store/prepare/serve sanitation (F812) and infection prevention/control (F880). The continued failure during 2 federal surveys of record showed a pattern of the facility's inability to	F 867	F- 867 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under	

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sustain an effective QAA program.

Findings Included:

This tag was cross-referenced to:

1. F812: Based on observation and staff interviews, the facility failed to 1) maintain the temperature of potentially hazardous cold foods at 41 degrees Fahrenheit or below (yogurt and milk) prior to delivery 2) label/date, store, and discard perishable foods beyond the use date in one of two kitchen refrigerators and failed to 3) allow plates to air dry prior to assemblage and stacking for one of two observations. These practices had the potential to affect all residents.

During the recertification survey that concluded on 5/12/22, the facility failed to maintain kitchen equipment clean, in good repair and in a sanitary manner to prevent cross contamination by failing to remove excessive ice and food debris from 2 of 4 freezers, failed to make repairs to a damaged freezer, failed to clean 1 of 2 ovens, 3 of 3 heating/ventilation/air conditioners (HVAC) filters, 1 of 1 can openers, and clean 1 of 1 nourishment room refrigerators.

On 9/26/23 at 10:59 AM, the Administrator was interviewed. He revealed that F812 was a repeat tag due to excessive turnover in the kitchen. He indicated that the Certified Dietary Manager (CDM) had been working unnecessary hours, as well covering open shifts. The Administrator stated that more education/auditing was needed for kitchen staff and follow-up actions to be performed by the management team.

2. F880: Based on observations, record review,

F 867

state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

How corrective action will be accomplished for resident(s) found to be affected:
F-812- no residents were affected.

F-880- no residents were affected.

How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed:
F-812- On 10/11/23 the Administrator conducted a dietary audit of the refrigerator, freezer, and the 2 nourishment refrigerators for accurate storage, dating, labeling, and proper food temperatures of perishable dairy products and the nesting of plates. Audit revealed that all food items were labeled and dated appropriately along with proper temperatures and plates were not stored wet.

F-880- On 10/11/23, the Administrator and Nurse manager provided an in-service for the laundry/housekeeping staff on IC, PPE and our policy and procedure on proper transporting of soiled linens, proper sorting, and handling.

What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
F-812- On 10/11/2023 the Administrator

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and staff interviews, the facility failed to implement their infection control policy and policy for handling soiled linen. Laundry Aide #1 was observed having soiled linens come in contact with her clothing while sorting them into the washing machine and transferring unbagged soiled linens from a soiled linen bin on a resident hall to an open laundry basket to transport the linens to the laundry room for 1 of 2 laundry aides observed (Laundry Aide #1).

During the recertification survey that concluded on 5/12/22, the facility failed to implement a Legionella prevention program. This deficient practice had the potential to affect all 44 residents.

The Administrator was interviewed on 9/27/23 at 1:40 PM. He revealed that the F880 tag was a repeat due to the turnover of staff and recent change of ownership.

F 867

re-educated the Dietary Manager including all dietary staff regarding the requirements for accurate food temperatures, storing, dating, and labeling of food items in the refrigerator, freezer, and the 2 nourishment refrigerators, food temperatures perishable dairy items along with proper storage of cleaned plates.

F-880- On 10/11/23, the Regional Nurse consultant provided Infection Control, PPE in-services to the housekeeping/laundry staff to include proper handling, storage and transporting of soiled linens . This will be done upon hire and annually thereafter, in addition to training housekeeping/laundry staff on our policy and procedures for handling soiled linens.

Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:
F-812- Monitoring will be done by the Administrator, or designee to monitor and ensure that through observation, the refrigerator, freezer, and the 2 nourishment refrigerators for proper food temperatures, accurate dating, labeling, and storage of food items along with proper food temperatures of perishable dairy items, and that plates are cleaned and stored properly. This monitoring process will take place weekly for 4 weeks then monthly for 2 months.

F-880- A monitor sheet will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that housekeepers/laundry personnel are

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F 867	Continued From page 43	F 867	handling, transporting, and sorting soiled linen appropriately. The monitoring process will be daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		10/11/23

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F 880	Continued From page 44 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement their infection control policy and policy for handling soiled linen. Laundry Aide #1 was observed having soiled linens come in contact with her clothing while sorting them into the washing machine and transporting soiled linens from a resident hall to the laundry room in a wire laundry basket with no lid for 1 of 2 laundry aides observed (Laundry Aide #1). The findings included: Review of the facility policy titled "Infection Prevention and Control Program" last reviewed/revised in January 2023 revealed was to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy further read "laundry and direct care staff shall handle, store, process, and transport linens to prevent the spread of infection. The environmental services staff shall not handle soiled linen unless it was properly bagged." Review of the facility policy titled "Handling Soiled Linen" (no date) revealed all used linen should be handled using standard precautions and treated as potentially contaminated. The policy stated all used or soiled linen shall be collected at the	F 880	F-880 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. (1) How corrective action will be accomplished for resident(s) found to have been affected No residents were affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: On 10/11/23, the Administrator and Nurse manager provided an in-service for the laundry/housekeeping staff on IC, PPE and our policy and procedure on proper transporting of soiled linens, proper	

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F 880	Continued From page 46 bedside (or point of use) and placed in a bag or designated lined receptacle and when task complete the bag should be closed securely. The policy also stated the linen should not be allowed to touch the uniform or floor and should be handled as little as possible to avoid contamination of air, surfaces, and persons. The policy further stated the sorting of contaminated linen at the point of use such as hallways or other open resident care spaces was prohibited. a. An observation on 9/24/23 at 11:37 am revealed Laundry Aide #1 was observed pushing a wheeled wire laundry basket of soiled linen with a white sheet over the top of the soiled linens into the laundry room. She was observed to sort the visibly wet soiled linen from the wheeled laundry basket with gloves and place it into the washing machine. During the process of placing the visibly wet soiled linen in the washing machine the soiled linen touched the Laundry Aide #1's uniform on the left leg and hip area on three occasions. An interview was conducted with Laundry Aide #1 on 9/24/23 at 11:39 am who revealed she used gloves to sort the soiled linen and has at times gotten "stuff" on her arms and had to scrub them. Laundry Aide #1 stated she was not told to use a gown to sort soiled linen and the facility did not offer any personal protective equipment (PPE) to prevent the soiled linen from touching her uniform that she was aware of. No isolation gowns were observed in the soiled laundry area during the interview. An observation and interview were conducted on 9/25/23 at 1:57 pm with Laundry Aide #2 in the soiled laundry room who was observed to have a	F 880	sorting, and handling. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 10/11/23, the Regional Nurse consultant provided Infection Control, PPE in-services to the housekeeping/laundry staff to include proper handling, storage and transporting of soiled linens . This will be done upon hire and annually thereafter, in addition to training housekeeping/laundry staff on our policy and procedures for handling soiled linens. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that housekeepers/laundry personnel are handling, transporting, and sorting soiled linen appropriately. The monitoring process will be daily for 2 weeks, weekly for 2 weeks, then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 880	Continued From page 47	F 880		

blue cloth gown over her clothing while sorting soiled linen from the large gray laundry container. Laundry Aide #2 stated the facility had blue cloth gowns to wear over their clothing when sorting soiled linen and that the gowns were in a box on the clean side of the laundry room. She stated the facility provided education in the past to wear a gown when sorting soiled linen.

An interview was conducted on 9/26/23 at 10:32 am with the Maintenance Director who revealed he was responsible for the oversight of Laundry Aide #1. He stated the facility had blue isolation gowns that were available for staff to wear when collecting and sorting soiled linen. The Maintenance Director stated in the past he was only responsible for the maintenance of equipment and ordering supplies and the previous Staff Development Coordinator was responsible for the education and discipline of the department. He stated the previous Staff Development Coordinator gave varied information to staff regarding handling of soiled linen so Laundry Aide #1 may have been confused.

A telephone interview was conducted with the Administrator on 9/27/23 at 11:21 am who revealed the IP was responsible for providing education to staff regarding the handling of soiled linen.

During an interview on 9/25/23 at 11:29 pm with the Infection Preventionist (IP) she revealed she was new to the position, and she did not know the facility's policy on handling soiled linen.

b. An observation on 9/25/23 at 9:01 am revealed Laundry Aide #1 removed soiled linen from the soiled linen bin located in the resident

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F 880	Continued From page 48	F 880		

hallway and placed the linen into a wheeled wire laundry basket with no lid. Laundry Aide #1 continued to the next soiled linen bin and repeated the process of placing the soiled linen in the wire laundry basket with no lid. Laundry Aide #1 was then observed to cover the top of the wheeled wire laundry basket with a sheet and leave the resident hall and proceed to the laundry room.

An interview was conducted with Laundry Aide #1 on 9/25/23 at 9:25 am who stated she did not like to use the large gray laundry bin that was fully enclosed with a lid because it was hard to push and difficult to get the soiled items out of it.

An observation and interview were conducted on 9/25/23 at 1:57 pm with Laundry Aide #2 in the soiled laundry room who stated the soiled linen on the hall was to be placed in the large gray laundry container with the lid closed when transporting to the laundry area.

An interview was conducted on 9/26/23 at 10:32 am with the Maintenance Director who revealed he was responsible for the oversight of Laundry Aide #1. He stated in the past, he was only responsible for the maintenance of equipment and ordering supplies and the previous Staff Development Coordinator was responsible for the education and discipline of the department. The Maintenance Director stated the facility had large fully enclosed laundry bins with lids that were to be used to gather soiled linen from the nursing halls. The Maintenance Director stated the wheeled wire laundry basket was used for clean linen and should not have been used to transport soiled linen since it was not fully contained.

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F 880	Continued From page 49 A telephone interview was conducted with the Administrator on 9/27/23 at 11:21 am who revealed the IP was responsible for providing education to staff regarding the handling of soiled linen. During an interview on 9/25/23 at 11:29 am with the Infection Preventionist (IP) revealed she was new to the position and had not received training on the facility's infection control policy and the handling of soiled linen.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be	F 882	F- 882 This plan of correction constitutes a	10/16/23

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F 882 Continued From page 50

responsible for the facility's Infection Prevention and Control Program.

The findings included:

During an interview with the Interim Director of Nursing (DON) on 9/24/23 at 11:30 am she revealed the Infection Preventionist (IP) was responsible for the facility's Infection Prevention and Control Program. The DON stated the IP was new to the position and had not completed any of the required training programs for the IP position yet. The DON stated the facility did not have any staff members with specialized training to meet the qualifications for the IP role.

An interview was conducted with the IP on 9/25/23 at 11:29 am who revealed she was new to the position and the facility planned for her to attend the next training session to complete the required specialized training. She stated she was shown how to monitor infections in the facility but had not had any other education regarding the Infection Prevention and Control Program.

During an interview on 9/26/23 at 11:21 am the Administrator revealed he was aware the IP had not completed the required training for the Infection Preventionist position. The Administrator stated he was aware the IP role required specialized training, but he thought the Interim DON had completed the training and would be responsible until the IP was able to complete the training.

F 882

written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

How corrective action will be accomplished for resident(s) found to be affected:
No residents were affected.

How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents.

What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
The Regional Nurse Consultant hired an RN, Director of Nursing who is SPICE certified and will start on October 16, 2023. The Nurse Manger is also signed up for the SPICE program in November 2023.

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F 882	Continued From page 51	F 882	Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained: Monitoring will be done by the Administrator and Director of Nursing to ensure that there is always a SPICE certified nurse employed. IP SPICE certification will be accessible in the employee□s file. This monitoring will be monthly for 6 months. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been	F 883		10/16/23

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F 883	Continued From page 52 immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive	F 883		

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F 883

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the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to assess residents for eligibility and ensure residents were offered the pneumococcal vaccine upon admittance to the facility for 2 of 5 residents reviewed for immunizations (Resident #12 and Resident #33).

The findings included:

The facility policy for Pneumococcal Vaccine last reviewed on 8/31/22 read in part "to encourage qualifying residents to have a pneumococcal vaccine appropriate to their age and medical conditions. Upon admission the resident and/or their responsible party will be educated about and offered the pneumococcal vaccine. The resident/responsible party will sign a consent and the facility will maintain an immunization record".

a. Resident #12 was admitted to the facility on 6/14/22 with a diagnosis of Parkinson's disease.

The Minimum Data Set (MDS) quarterly assessment dated 8/23/23 revealed Resident #12 was not up to date with the pneumococcal vaccine and that it was not offered.

Review of Resident #12's immunization record revealed no documentation that he or his responsible party had been offered, provided with education, given, or refused the pneumococcal vaccine.

During an interview on 9/25/23 at 11:29 am the Infection Preventionist revealed she was new to

F 883

F- 883

This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

How corrective action will be accomplished for resident(s) found to be affected:
Resident #12 and resident #33 were offered the pneumococcal vaccine.

How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed:
All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents.

What measure(s) will be put in place or

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the position and did not know about offering pneumococcal vaccinations to residents upon admission. The Infection Preventionist was unable to state why Resident #12 was not offered the pneumococcal vaccination.

An interview was conducted with the MDS Nurse on 9/26/23 at 12:59 pm who revealed she reviewed the admission record for Resident #12, and it did not show that he had received the pneumococcal vaccine prior to admission. The MDS Nurse stated she documented the resident was not up to date because the vaccine was appropriate for Resident #12. The MDS Nurse reported she had requested the facility provide pneumococcal vaccines for residents, but she stated the previous ownership did not offer the pneumococcal vaccine to residents due to the high cost of the vaccine.

During a telephone interview with the Administrator on 9/27/23 at 1:17 pm he revealed he was not aware pneumococcal vaccines were not offered to residents upon admission. The Administrator stated the previous owner was in charge of obtaining pneumococcal vaccines and she did not share any information regarding not ordering the vaccine.

b. Resident #33 was admitted to the facility on 8/18/20 with diagnoses which included stroke and heart failure.

The Minimum Data Set (MDS) annual assessment dated 7/06/23 revealed Resident #33 was not up to date with the pneumococcal vaccine and that it was not offered.

Review of Resident #33's immunization record

F 883

systemic changes made to ensure that the identified issue does not re-occur in the future:
On 10/16/23 the Interim DON and Nurse Manager conducted an audit of all residents for receiving the Pneumococcal vaccine. Residents who were not offered the vaccine were asked if they wanted to receive the Pneumococcal vaccine. Residents with responsible parties were notified for consent or declines. Nursing staff were educated by the Nurse Manager on 10/16/23 to offer the Pneumococcal vaccine upon admission. Daily monitoring of all new admissions for Pneumococcal vaccine consent or decline.

Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:
Monitoring will be done by the Director of Nursing or designee to monitor and ensure that the pneumococcal vaccine is being offered upon admission. The monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility

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F 883	Continued From page 55 revealed no documentation that he or his responsible party had been offered, provided with education, given, or refused the pneumococcal vaccine. During an interview on 9/25/23 at 11:29 am the Infection Preventionist revealed she was new to the position and did not know about offering pneumococcal vaccinations to residents upon admission. The Infection Preventionist was unable to state why Resident #33 was not offered the pneumococcal vaccination. An interview was conducted with the MDS Nurse on 9/26/23 at 12:59 pm who revealed she reviewed Resident #33's record and it did not show that he had received the pneumococcal vaccine previously. The MDS Nurse stated she documented the resident was not up to date since the vaccine was appropriate for Resident #33. The MDS Nurse reported she had requested the facility provide pneumococcal vaccines for residents, but she stated the previous ownership did not offer the pneumococcal vaccine to residents due to the high cost of the vaccine. During a telephone interview with the Administrator on 9/27/23 at 1:17 pm he revealed he was not aware pneumococcal vaccines were not offered to residents upon admission. The Administrator stated the previous owner was in charge of obtaining pneumococcal vaccines and she did not share any information regarding not ordering the vaccine.	F 883	remains in substantial compliance.	
F 925 SS=G	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control	F 925		10/2/23

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F 925	Continued From page 56 program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and Physician, resident, Responsible Party (RP), and staff interviews the facility failed to provide a pest free living environment for 1 of 1 resident residing in the facility (Resident #42). The facility's failure contributed to Resident #42 sustaining a rash to her arms and legs due to ant bites resulting in itching and discomfort. The Findings included: Resident #42 was admitted to the facility on 6/12/23 with diagnoses that included dementia, diabetes, and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 9/16/23 revealed the Resident was moderately cognitively impaired and required extensive 1-2 staff member assistance with all activities of daily living including bed mobility. Resident #42 was coded as having no limitations in her range of motion, clear speech, and had the ability to understand others. A review of the Pest Control Commercial Services Agreement dated 7/11/23 stated services would be provided weekly specifically targeting roaches, ants, and mice. The specifications of the service provided included treating all common areas, exterior and interior doorways, and exterior of the building for general pests. The pest control service report dated 7/18/23 revealed the perimeter of the facility was treated for black ants and roaches. The report indicated	F 925	F- 925 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. This plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. How corrective action will be accomplished for resident(s) found to be affected: All residents have the potential to be affected by this alleged non-compliance. How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed: On 10/2/23, the Administrator inspected the residents' rooms for any signs of ants or other pests. The observation revealed there we no pests observed in any of the residents' rooms. What measure(s) will be put in place or	

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common areas in the facility were spot treated for roaches only. The report did not specify if roaches or ants were observed during the visit.

The pest control service report dated 7/25/23 revealed the perimeter of the facility was treated for ants. The report did not specify if ants were observed during the visit.

A progress note dated 7/27/23 at 6:55am and written by Nurse #1 stated Resident #42 was moved to room 22 due to an ant infestation in her room (room 32). The note indicated ants were observed in her bed and scattered throughout her room.

A telephone interview was completed on 9/25/23 at 3:25pm with Nurse #1. The Nurse verified he worked nightshift on 7/26/23. Nurse #1 stated he was unable to recall providing care to Resident #42 or observing any pests in her room.

A review of the July 2023 Physician Order Summary revealed an order dated 7/27/23 for Triamcinolone Cream (steroid cream) 0.1% apply to rash 3 times daily for 14 days.

A telephone interview was completed on 9/26/23 at 3:56pm with Nurse Aide (NA) #1. The NA indicated she provided care for Resident #42 during the nightshift on 7/26/23. NA #1 stated she did not observe ants on the Resident or in her room during the night. The NA stated she did not see the Resident scratching her arms or legs during the shift. NA #1 stated she was notified by Nurse #6 he observed ants in the Resident's room on the morning of 7/27/23. The NA was unable to recall the exact time of her final check on the Resident.

F 925

systemic changes made to ensure that the identified issue does not re-occur in the future:
On 10/2/23 the Administrator notified the pest control company to request that they meet with him after their visits to get a status update. The weekly pest company visits are ongoing weekly and have been since early July when we acquired the facility.

Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:
Monitoring will be done by the Administrator or designee to ensure the resident rooms are pest free by walking rounds and room inspections. The monitoring process will take place daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345316	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 09/27/2023

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F 925	Continued From page 58 The NA stated she did not recall Resident #42 scratching her arms during any shifts she was assigned to care for her. A telephone interview was completed on 9/27/23 at 9:15am with Nurse #6. The Nurse verified he was assigned to provide care for the Resident during the day shift on 7/27/23. Nurse #6 stated when he arrived at the facility, Resident #42 had already been moved to a new room (22). The Nurse revealed he did not observe any ants on the Resident in the new room (22) and did not go in the Resident's previous room during his shift. Nurse #6 stated he observed red areas scattered on the Resident's arms and legs. The Nurse indicated the Medical Director was notified, assessed the resident, and prescribed Resident #42 a cream for the rash. Nurse #6 stated Nurse #1 informed him of the ant infestation in Resident #42's room during shift report on 7/27/23. Nurse #6 revealed he observed Resident #42 intermittently scratching her arms approximately 2-3 days after sustaining the ant bites, but the prescribed steroid cream decreased the Resident's scratching. The Nurse stated he had not observed ants in any other Resident rooms. A telephone interview was completed on 9/24/23 at 10:20am with Resident #42's RP. The RP revealed she arrived at the facility to visit the Resident at approximately 7:45am on 7/27/23. She was made aware the Resident had just been moved to a different room due to ants being observed in her room. The RP indicated she visited the Resident's previous room (32) on 7/27/23 and only observed small black ants on the Resident's bed. The RP stated she visited Resident #42 and observed a red rash scattered throughout her arms and legs and observed the	F 925		

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Resident scratching her arms. The RP revealed the resident's assigned nurse informed her the Physician had been notified and an order was obtained for a steroid cream. The RP stated she had not observed pests in Resident #42's room prior to 7/27/23 and had not observed them since.

Undated pictures of Resident #42's room were provided by the RP. The pictures revealed an empty bed with approximately 10-12 small black ants crawling on the bottom sheet.

An observation of Resident #42 was completed on 9/24/23 at 11:55am. No rash was observed on the Resident's arms or legs, and no pests were observed in her room. Resident #42 was questioned if she recalled the ants on 7/27/23 and she shook her head no.

Observations of the facility's common areas and resident rooms on 9/24/23 at 10:00am yielded no observations of pests.

Observations of the facility's common areas and resident rooms on 9/25/23 at 3:35 pm yielded no observations of pests.

The pest control service report dated 8/1/23 revealed the perimeter and common areas of the facility were treated for roaches. The report did not specify if roaches were observed during the visit or anything about ants being observed in Resident #42's room on 7/27/23.

The pest control service report dated 8/8/23 revealed the perimeter of the facility was treated for roaches. The report did not specify if roaches were observed during the visit.

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The pest control service report dated 8/15/23 revealed the perimeter of the facility was treated for roaches and ants. The report did not specify if roaches or ants were observed during the visit.

The pest control service report dated 8/22/23 revealed the perimeter of the facility was treated for roaches and ants. The report did not specify if roaches or ants were observed during the visit.

The pest control service report dated 8/29/23 revealed the perimeter of the facility was treated for roaches. The report did not specify if roaches were observed during the visit.

The pest control service report dated 9/5/23 revealed the perimeter of the facility was treated for roaches. The report did not specify if roaches were observed during the visit.

A telephone interview was completed on 9/25/23 at 2:23pm with the former Director of Nursing (DON) #1. The DON stated she was made aware of ants in Resident #42's room when she arrived at the facility on 7/27/23. She revealed at the time of her arrival, the Maintenance Director had already been notified, exterminated the ants, and had housekeeping cleaning the room. She further stated staff had already moved the Resident to a clean room and notified the RP and Medical Director. Former DON #1 stated she did not observe ants in the Resident's old room. The DON stated she was unsure of what attracted the ants to Resident #42's room. She revealed housekeeping staff cleaned the room and the Maintenance Director verified all ants were exterminated from the room.

An interview was completed on 9/26/23 at

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F 925	Continued From page 61 9:30am with the Medical Director. The Medical Director indicated she assessed Resident #42 on 7/27/23. The Medical Director stated she observed a red rash scattered throughout the Resident's arms and legs. She indicated the rash appeared to be ant bites. The Medical Director stated she was unable to recall if the Resident was scratching the rash during her visit. The Medical Director stated she prescribed a steroid cream to treat the rash, and the rash was healed approximately 1 week later. A telephone interview was completed on 9/26/23 at 12:27pm with the Pest Control Technician. The Technician stated his company began providing services in July 2023. He stated he visited weekly to treat the facility for pests, which included ants and roaches. The Technician stated on his first visit, 7/18/23, roaches were observed in common areas throughout the facility. The Technician stated during his visits, he sprayed the perimeter of the building, inspected high probability areas (kitchen, staff breakroom, common areas) and treated as needed. He revealed during each visit he inspected a set number of Resident rooms for pests, and by the end of each month he had inspected all areas of the facility. The Technician stated outside food brought in and eaten in Resident rooms was a contributing factor to pests in rooms. He indicated he had spoken with housekeeping staff and the Administrator regarding residents eating food in their rooms and the importance of eliminating food particles after the resident had eaten. The Technician was unable to recall what rooms were treated during each visit. He revealed he treated the perimeter of the building for ants and roaches on 7/25/23 and did not recall observing ants in the facility. The Technician stated he did not recall being	F 925		

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F 925	Continued From page 62 contacted on 7/27/23 regarding ants, and his next service day was 8/1/23. The Technician stated he did not observe ants in the facility on 8/1/23. He stated the observation of pests had decreased dramatically since he started providing services to the facility. The Technician stated it was his opinion the facility was doing everything possible to eliminate any pests that entered the building. An interview was completed on 9/26/23 at 1:34pm with the Maintenance Director. The Director stated the pest control company visited weekly to spray the exterior of the building. He revealed the company inspected the building and spot treated areas during each visit. The Maintenance Director stated when pests were observed in between the pest company's visits, he eliminated them and notified the pest company at their next visit. The Maintenance Director stated he was notified when he arrived the morning (unable to recall time) of 7/27/23 by staff, ants were found in Resident #42's room (32). The Director stated he observed ants around the windowsill and several scattered on the floor (approximately 20). He did not recall seeing ants in the Resident's bed. The Maintenance Director stated vacuumed the ants up, sprayed the areas where ants were observed, and had housekeeping thoroughly clean the room. He indicated he did not contact the pest company because they were scheduled to visit on 8/1/23. The Director stated food in resident rooms attracted the pests but was unable to recall if he observed food or crumbs in Resident #42's room. The Director stated since the new Pest Company began providing services in July 2023 and he had not observed ants in the facility since 7/27/23. An interview was completed on 9/27/23 at	F 925		

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F 925	Continued From page 63 1:02pm with the Interim DON. The DON stated she felt the pest control issue in July 2023 was a result of the failure of the previous facility owners and pest control company to maintain an effective pest control program. The DON stated when the current pest control company began providing services in July 2023 the observation of pests had decreased. An interview was completed on 9/27/23 at 1:21pm with the Administrator. He indicated when the facility identified ongoing observations of pests (roaches only) with the prior pest company, the facility contracted with a new pest control company to begin providing services. The Administrator stated he felt due to the age of the building and the prior pest control company only treating the outside of the building this did not fully eliminate the pests. He revealed he had not observed ants in the facility. The Administrator stated the facility thoroughly sanitized Resident #42's room on 7/27/23 and made the Pest Technician aware of the ants during his visit on 8/1/23. He revealed Resident #42's room (32) was treated for ants prior to being moved back into it. The Administrator stated the new pest control company began providing services on 7/18/23 and had been servicing the facility weekly since that time.	F 925		