STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 11/28/23 through 11/30/23. The facility was not found to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The following intakes were investigated: NC00209135, NC00210071 and NC00210419. Two (2) of the 3 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/7/23

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

Electronically Signed | 12/05/2023

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to treat a resident with dignity when Nurse Aide (NA) #1 adjusted Resident #8 down in the bed by his ankles when the resident asked to be moved down in the bed for 1 of 3 residents reviewed for dignity (Resident #8). The findings included: Resident #8 was admitted to the facility on 10/06/23 with diagnoses which included generalized muscle weakness, chronic pain, vertebral compression fractures, and lymphedema. Resident #8's admission Minimum Data Set (MDS) assessment dated 10/12/23 revealed he was cognitively intact and required substantial/maximal assistance with toileting,	F 550	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Social Work Director, met with	

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F 550	Continued From page 2 showering, lower body dressing, and putting on and taking off footwear, partial/moderate assistance with upper body dressing and dependent with transfers with mechanical lift. Resident #8's care plan dated 10/12/23 had a focus area for needing assistance with activities of daily living (ADL) due to impaired mobility and compression fractures. The interventions included the resident needed extensive assistance of 1 to 2 staff with repositioning, extensive assistance of 1 staff with bathing, and assistance of 2 staff with transfers using mechanical lift. Interview on 11/28/23 at 10:50 AM with Resident #8 revealed he had an issue with a male Nurse Aide (NA) about a month ago or shortly after he was admitted to the facility. He stated the male NA had given him a shower along with another female Nurse Aide (NA) and when they had put him back to bed after his shower, he was too far up towards the head of the bed so he had asked the male NA to help him move down in the bed and the male NA took Resident #8 by the ankles and "jerked" him down in the bed. Resident #8 further stated he told the male NA not to ever do that to him again because he had back problems and that was not the way to move him down in bed. He said he had reported the incident to the Social Worker and to his nurse (Nurse #3) on that day. Resident #8 indicated the Social Worker had told him that she would take care of the situation. He described the male NA as being 5 foot 10 inches or taller, bulky, weighing more than 200 pounds and described his skin color. Resident #8 stated he had only had him on the one day that he gave him a shower and had not seen him since. He further stated it hurt his	F 550	Resident #8 on 11-28-2023 and made him aware that the NA#1 had been removed from working at the facility on 11-9-2023 and that he would not be allowed to work at the facility going forward and apologized for the way NA#1 repositioned him in bed. He was asked if he had received care appropriately since the incident that occurred with NA#1. He reported that he had no concerns. Resident #8 was assessed by the charge nurse assigned to him on 11-28-2023 to determine if there was any injury to his back and or ankles because of the incident. The assessment findings was no injury was present which is consistent with Resident # 8's statement to the surveyor that he was not injured/hurt at the time the incident occurred. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 11-28-2023 the Administrator notified the Social Work Director and Administrative Assistant of the need to educate all staff on resident's rights that includes treating for and caring for residents in a respectful and dignified	

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F 550	Continued From page 3 ankles when he jerked him down in the bed because they were swollen anyway and was concerned it could have hurt his back but said it didn't. Interview on 11/28/23 at 4:30 PM with the Social Worker revealed Resident #8 had not reported the incident of him being jerked down in the bed by his ankles to her and said if he had she would have immediately reported the incident to the Administrator. She stated she was surprised he had not mentioned it to her because she was in his room almost daily to check on him but said since he had reported the incident, she would notify the Administrator immediately. The Social Worker further stated she considered Resident #8 credible and stated if he said someone jerked him down in the bed it probably happened to him. Telephone interview with Nurse #3 who was assigned to Resident #8 during the 7:00 AM to 7:00 PM shift on 10/17/23 revealed she had cared for Resident #8 on that day. Nurse #3 stated she did not remember Resident #8 telling her anything about someone jerking him down in the bed by the ankles. She stated she would have remembered something like that and would have immediately reported it to her Unit Manager. Nurse #3 further stated Resident #8 was alert and oriented and she would consider what he said to be credible. Review of the shower schedule revealed Resident #8 was scheduled for showers on Tuesdays and Fridays on first shift which is 7:00 AM to 7:00 PM. Review of the nursing schedules for October and November revealed on 10/17/23, Nurse Aide (NA)	F 550	manner. On 11-28-2023 the Administrative Assistant developed educational material that included an overview of the policy and procedures that address providing care to all residents in a respectful and dignified manner. A posttest was completed by the staff to demonstrate competency of the educational material provided to the staff. On 11-28-2023 the Director of Nursing and Administrative Assistant began re-educating all staff (full time, part time, and contract including agency staff) as described above. The Nurse Unit Manager/Director of Nursing and Administrator tracked to see what employees had been educated by running an employee listing and as each of them in-serviced the staff, they checked those staff members off the list. Any staff that did not receive the education by 11-28-2023 will not be allowed to work until they receive the education. The Nurse Unit Manager and/or Director of Nursing will be responsible for educating these staff members prior to them working. Newly hired employees and agency staff will be educated on the resident's right to be treated and cared for in a respectful and dignified manner during the orientation process. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.	

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F 550	Continued From page 4 #1 and NA #3 had worked together on the shower team giving showers on that day and it was a Tuesday and was Resident #8's shower day. Telephone interview on 11/29/23 at 10:46 AM with NA #1 revealed he had worked some days on the shower team and stated if he was on the schedule to work the shower team on 10/17/23 he must have worked with NA #3 giving resident showers. NA #1 described himself as being 5 feet 11 inches to 6 feet, weighing 230 pounds with average muscle mass and said his skin color was black. NA #1 stated he could not remember giving showers to any specific residents but did remember assisting NA #3 with showers at the facility. He further stated he didn't remember any specifics with any residents because he had been to so many different nursing homes to work. NA #1 indicated he didn't recall grabbing any resident by the ankles and jerking them down in the bed and didn't understand why he was being questioned. He said he had been a NA for 5 years and had never been questioned about his performance and hung up the phone. Interview on 11/29/23 at 10:10 AM with NA #3 revealed she worked the shower team frequently and stated different NAs assisted her on some days and some days she did the showers by herself. She reviewed the schedule on 10/17/23 and stated she couldn't recall the exact day but did remember NA #1 assisting her with showers from time to time and if they were on the schedule as giving showers that's what they had done on that day. On 11/29/23 at 10:24 AM NA #3 was accompanied into Resident #8's room and he told her he remembered her being with NA #1 the day	F 550	The Social Worker will interview 5 residents weekly for 4 weeks and then 5 residents monthly for 2 months to ensure care has been provided with respect and dignity. Audit results will be documented on the audit tool titled “Resident Rights: Dignity and Respect Interviews.” The Director of Nursing, Nurse Unit Manager, and/or Nurse Consultant or designee will observe at least 3 residents weekly for 4 weeks and 3 residents monthly for 2 months ensure care is provided with respect and dignity. Audit results will be documented on the audit tool titled “Resident Rights: Dignity and Respect Observation of Care.” Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Director of Nursing and/or Administrator where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 12-7-2023	

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F 550	Continued From page 5	F 550		

the incident occurred but said he didn't think she was in the room when NA #1 had jerked him down in the bed. Resident #8 told NA #3 he remembered her being in and out of the bathroom while NA #1 was giving him his shower and remembered her assisting NA #3 with the mechanical lift in getting him back to bed but Resident #8 didn't recall if NA #3 was in the room when NA #1 had taken him by the ankles and jerked him down in the bed. NA #3 told Resident #8 she did not recall anything happening that day after his shower. When NA #3 left Resident #8's room, she said she didn't see or hear anything about the incident on that day but said if the resident said it happened it must have happened.

Interview on 11/29/23 at 8:30 AM with Resident #8 revealed he had spoken with Administrative Assistant #1 and Social Worker on 11/28/23 and had told them about the male N.A "jerking" him down in the bed by his ankles. He stated he had reminded the Social Worker that he had told her about the male NA "manhandling" him in the bed but said she stated she didn't recall him telling her about the incident.

Interview on 11/29/23 at 9:50 AM with the Social Worker (SW) revealed the facility had started an investigation and Administrative Assistant #1 was pulling schedules for October and November and shower sheets on Resident #8 for October and November. She stated they had not determined who the male NA Resident #8 had described because the description given to them didn't match anyone working at the facility.

Interview on 11/30/23 at 4:34 PM with the Director of Nursing (DON) revealed it was her practice to side with the resident and especially given

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F 550	Continued From page 6	F 550		

Resident #8 was able to give a description of the NA that fit the description of NA #1 and there were other incidents that had occurred with residents and a complaint against NA #1 from another resident. The DON stated she sat down with the facility team on 11/09/23 and told them NA #1 was not someone they wanted working with the residents at the facility since he had been taking care of a resident who had a fall and fracture and another resident had accused him of feeding him too fast. The DON further stated given the 2 incidents that occurred within days of each other, she had contacted law enforcement in the process of their investigation of the complaint filed by resident of being fed too fast by NA #1 and said he had been escorted out of the building on 11/09/23 by law enforcement. The DON explained she had contacted his agency and asked that he not return to the facility effective 11/10/23.

Interview on 11/30/23 at 5:17 PM with the Administrator revealed she had just talked with NA #3 who was with NA #1 on 10/17/23 and NA #3 didn't recall anything about this incident happening while in Resident #8's room providing care. The Administrator stated she had also talked with NA #1 before coming upstairs on 11/30/23 for about an hour on the telephone and he denied adjusting the resident down in the bed by his ankles. She stated NA #1 wanted to know why he had been called by so many people asking questions and questioning his care to residents. The Administrator said they were still investigating the incident and had not made any conclusions as to what may have happened to Resident #8. She further stated Resident #8 was alert and oriented and considered credible with what he had reported.

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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: Based on record review, observation, and interviews with resident, staff, and the Medical Director, the facility failed to use a mechanical lift to transfer a non-ambulatory resident (Resident #1) for 1 of 3 residents reviewed for accidents. Resident #1 sustained a distal femoral periprosthetic (structure in close relation to an implant) fracture of the left knee after Nurse Aide #1 attempted to transfer her from bed to wheelchair by putting his hands on her and supporting her by holding the back of her pants after her knees buckled as soon as she stood up. The findings included: Resident #1 was admitted to the facility on 6/28/23 with diagnoses that included cerebral infarction (stroke), generalized muscle weakness, and cognitive communication deficit. Resident #1's care plan initiated on 7/18/23 indicated Resident #1 had an activities of daily living self-care performance deficit related to stroke. She did not stand or ambulate. She preferred to remain in bed much of the time. Resident #1 required mechanical lift with staff assistance for transfers. Resident #1's care plan	F 689	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 11/7/23 Nurse # 1 performed a head-to-toe assessment and took vital signs for Resident #1. After the assessment, Nurse #1, NA#1, and NA#2 assisted Resident # 1 back into bed. Nurse # 1 medicated the Resident #1 for left knee pain and notified the Physician Assistant (PA) who was in the	12/7/23

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F 689	Continued From page 8 further indicated that she was at risk for further injury from falls related to impaired cognition. She believed that she could walk but she had not ambulated in over three years per her family member. Interventions included mechanical lift for transfers and no ambulation. The quarterly Minimum Data Set (MDS) assessment dated 9/30/23 indicated Resident #1 was severely cognitively impaired and required extensive assistance by one person physical assist with bed mobility. Transfer occurred only once or twice during the assessment period, and she required extensive physical assistance. She also required substantial/maximal assistance with lying on her back to sitting on the side of her bed. An untitled and undated report sheet listed all the residents on 200 hall with their shower information, assistance needed, transfer and continence status. Included in this list was Resident #1 and it indicated that she required total assistance and used a mechanical lift for transfers. An incident report dated 11/7/23 at 8:30 AM for Resident #1 indicated that at approximately 8:30 AM, the nurse aide (Nurse Aide #1) was getting Resident #1 up for breakfast when the nurse (Nurse #1) informed him that the resident did not get up for breakfast. Nurse #1 continued with her medication pass when Nurse Aide (NA) #1 came out of Resident #1's room and stated that she was on the floor and asked if she would help him get her back into bed. Nurse #1 asked what happened and was told that her legs gave out while transferring her to the wheelchair from the bed, and that he assisted her to the floor to get help. Nurse #1 walked into the room and	F 689	facility at the time of the incident. Nurse #1 notified the family member that same day (11/7) of the incident when they visited the Resident. The Physician Assistant (PA) assessed Resident #1 and ordered X-rays and non-weight bearing on the left extremity until X-ray results were obtained. Resident #1 was transported to the Emergency Department on 11/8/23. The Director of Nursing met with NA#1 to obtain a written statement as to the NA's personal accounting of the incident that occurred. On 11//7/23 the Director of Nursing and Unit Manager reviewed Resident #1's Kardex to ensure the transfer method was accurate. On 11/9/23 the Director of Nursing contacted the Staffing Agency and requested NA#1 not be sent back to the facility to work. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 12/4/23 all residents transfer status on the Kardex was compared to the resident care plan to make sure the information was accurate. This was completed by the MDS Coordinator. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	

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F 689	Continued From page 9 Resident #1 was sitting on the floor. She performed a head to toe assessment and took her vital signs. Resident #1 denied hitting her head or having any pain other than left knee pain. Vital signs were within normal limits and two nurse aides (NA #1 and NA #2), and Nurse #1 helped Resident #1 back into bed. Nurse #1 medicated the resident for pain and notified the Physician Assistant (PA) who was in house at the time of the fall. The PA assessed Resident #1 and ordered x-rays. Resident #1's family member came to visit and was notified. A typed statement of NA #1 taken via phone by the Interim Director of Nursing on 11/10/23 indicated that on 11/7/23 early morning, Resident #1 was trying to get out of bed. The resident said she could walk. NA #1 said let's try. Resident #1 slid to the floor and landed on her knees. There was no one else in the room at the time. NA #1 called for assistance. Nurse #1 and NA #2 helped NA #1 pick her up to put her back in bed. NA #1 told Resident #1's family member what happened when she came to the nursing station later day. An initial phone interview with NA #1 on 11/28/23 at 4:15 PM revealed during the fall incident on 11/7/23, Resident #1 slipped and fell to the floor from her bed. NA #1 stated that right before the incident, he asked her if he needed to use a mechanical lift on her and she told him no. Resident #1 had stated she was able to walk and get up by herself and that she had been working with therapy. She tried to get up and slid to the floor while he tried to ease her to the floor. A follow-up phone interview with NA #1 on 11/29/23 at 10:39 AM revealed when he was	F 689	On 12/4/23 the Administrator notified the Director of Nursing, the Director of Nursing in training and Nurse Unit Manager of the need to educate all direct care staff (licensed nurses and Nursing Assistants) that includes full time, part-time and agency staff on how to a) access the care guide/Kardex that provides guidance on activities of daily living according the resident care plans, and b) utilizing the “resident transfer status sheets” for specific transfer technique/assistance. A return demonstration (that included accessing the care guide/Kardex and locating the transfer status sheets) was completed with all staff to demonstrate comprehension of the education provided. The Nurse Unit Manager, Director of Nursing, Director of Nursing in training and Administrator tracked to see what employees had been educated by running an employee listing and as each of them in-serviced the staff, they checked those staff members off the list. Any staff that did not receive the education by 12-5-2023 will not be allowed to work until they receive the education. The Nurse Unit Manager and/or Director of Nursing will be responsible for educating these staff members prior to them working. Newly hired employees and agency staff will be educated on how a) to access the care guide/Kardex that provides guidance on activities of daily living according the resident care plans, and b) utilizing the	

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F 689	Continued From page 10 assigned to care for Resident #1 on 11/7/23, he was not familiar with Resident #1 but when he went into her room, she was anxious, and she was trying to get up. Her upper body was up but her legs were still on the bed. NA #1 stated that this was the first time he saw Resident #1 moving in her bed and she usually stayed in her bed. NA #1 stated that he told her to slow down, hold on and wait but he couldn't stop her from getting on her feet. NA #1 stated that he was not aware of Resident #1's transfer status and he did not receive report from the outgoing shift. NA #1 denied being told by Nurse #1 not to get up Resident #1 for breakfast. NA #1 further revealed that he usually asked his residents if they wanted to get up or not, and whether he needed to use a mechanical lift or not. He stated he did not know anything about a report sheet or a Kardex and that the facility did not have a system of communicating the transfer status of each resident to the nurse aides especially to the agency aides. NA #1 stated that he was an agency aide, and he was used to this practice at any facility he worked. He emphasized that Resident #1's fall was not his fault and that it was Resident #1's fault because she told him that she could stand up and she even said to him to get out of her way. Then she slid down to the floor from a sitting position on the side of her bed. NA #1 shared that Resident #1 was not able to stand up on her legs when her legs gave out, so he supported her by holding the back of her pants through the waist. Resident #1's buttocks hit the floor first with her legs straight out in front of her. NA #1 alerted Nurse #1 who came to the room to assess Resident #1. NA #1, NA #2 and Nurse #1 assisted Resident #1 off the floor back to her bed by manually lifting her up as directed by Nurse #1. NA #1 and NA #2 lifted Resident #1 by	F 689	"resident transfer status sheets" for specific transfer technique/assistance during the orientation process. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing, Director of Nursing in training, Nurse Unit Manager, and/or Nurse Consultant or designee will observe at least 3 residents being transferred weekly for 4 weeks then monthly for 2 months to ensure they are transferred according to the resident care guide/Kardex and transfer status sheets. Audit results will be documented on the audit tool titled "Transfer observations." Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Director of Nursing and/or Administrator where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 12-7-2023	

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holding her under each arm while Nurse #1 held Resident #1's ankles.

A typed statement signed by Nurse #1 on 11/12/23 indicated that on 11/7/23 at approximately 8:30 AM, NA #1 was getting Resident #1 up for breakfast. Nurse #1 informed him that Resident #1 did not get up for breakfast. Nurse #1 continued with her medication pass. NA #1 came out of Resident #1's room and stated that she was on the floor and asked if she would help him get her up and back to bed. Nurse #1 asked him what happened. NA #1 told Nurse #1 that as he was transferring her from the bed to the wheelchair, she had weakness in both legs, and he assisted her to the floor. Nurse #1 walked in the room and did a head-to-toe assessment and took her vital signs. Resident #1 was complaining of left knee pain. Two nurse aides and Nurse #1 assisted her off the floor to bed. Nurse #1 medicated her for pain, notified the PA who was in-house at the time of her fall. The PA assessed Resident #1 and ordered x-rays. Resident #1's family member came in to visit and was notified.

A phone interview with Nurse #1 on 11/29/23 at 10:28 AM revealed on the morning of 11/7/23, NA #1 was getting the residents up for breakfast and he went into Resident #1's room to get her up. Nurse #1 stated that she told NA #1 that Resident #1 usually stayed in bed for breakfast, but NA #1 stated that Resident #1 was on his list of residents to get up, so he was going to get her up. Nurse #1 stated that she proceeded with her medication pass when she heard NA #1 asking for help in Resident #1's room. NA #1 told her that he was transferring Resident #1 from the bed to her wheelchair and both of her legs gave out.

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NA #1 assisted Resident #1 to the floor. Nurse #1 shared that she obtained Resident #1's vital signs and assessed her for any signs of injuries. She asked Resident #1 if she was having any pain and Resident #1 complained of pain of the left knee. After she assessed that Resident #1 was safe to be moved off the floor, NA #1 and NA #2 both grabbed under each arm while Nurse #1 held both ankles. Nurse #1 stated that Resident #1's legs were straight out, and she tried to move her legs as little as possible, so she grabbed her by both ankles. Nurse #1 further revealed that Resident #1 complained of pain the whole time they moved her from the floor to the bed. She stated that Resident #1 usually favored her left side and she tended to lean towards the left and when she was back in the bed, she complained of pain to the whole left lower extremity from the hip to the ankle. Nurse #1 propped Resident #1's left leg on a pillow and when she palpated over her left knee, Resident #1 complained of pain. Resident #1 was not able to give a pain rating, but she was crying and grimacing. Nurse #1 did not observe any obvious deformities. She medicated Resident #1 for pain with Acetaminophen and notified the PA who was at the facility at that time. The PA ordered an x-ray and then she notified Resident #1's family member. Nurse #1 further shared that she was not entirely sure about Resident #1's transfer status and that she would have to look it up, but she knew that the nurse aides had a report sheet that indicated the residents' transfer status. Nurse #1 stated that since being back from the hospital, Resident #1 had not been eating much and she stayed asleep all the time because they kept her medicated for pain. Nurse #1 said that she asked Resident #1 frequently about her pain level and she received pain medications as

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needed. Resident #1 did not get up out of the bed anymore and had refused to get up due to pain on her left knee. Nurse #1 stated that prior to the fall, Resident #1 was not able to get herself to a sitting position on the side of the bed. She required total assistance from staff to do this.

Resident #1's November 2023 Medication Administration Record (MAR) indicated Resident #1 was monitored for pain every shift. On 11/7/23, she had a pain level of 7 out of 10 (0 being no pain and 10 being severe pain) on the day shift after the fall and she received Acetaminophen 650 milligrams (mg) at 9:00 AM. During the evening shift on 11/7/23, she was assessed as having pain level of 3 out of 10 but she did not receive any pain medication. On 11/8/23, Resident #1 had a pain level at 8 out of 10 and was given Acetaminophen 650 mg at 2:07 PM.

An interview with NA #2 on 11/29/23 at 2:28 PM revealed she was the other nurse aide who worked with NA #1 on 11/7/23 but she was assigned to the other side of the hall. NA #2 stated that Nurse #1 alerted her and told her that she needed assistance with a fall. When she entered Resident #1's room, NA #1 was in the room with Resident #1 who was sitting up on the floor. NA #2 stated she grabbed the mechanical lift to get Resident #1 off the floor, but the mechanical lift would not lower all the way down to the floor. NA #1 stated the battery probably needed to be charged so they couldn't use the lift. Nurse #1 instructed NA #1 and NA #2 to grab Resident #1 under both arms while Nurse #1 grabbed her ankles. NA #2 stated that she had not taken care of Resident #1 before the fall incident and was not familiar about what her

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transfer status was at that time. NA #2 shared that the residents' transfer status information could be found in a report sheet at each of the nurses' station and copies were kept in a folder. NA #2 stated that these sheets were given to the nurse aides especially the agency aides and they used them as reference so they would know how to take care of each resident.

A progress note dated 11/7/23 by the Physician Assistant (PA) indicated Resident #1 reported sliding out of chair to the floor, landing on her bottom and pain going all the way from her left hip to left knee, difficulty moving her leg. She did not believe she had lower back pain but did land on her tailbone. She denied numbness or tingling in extremity but reported left hip and left knee pain. She recently took Acetaminophen and Ibuprofen with some pain relief, but still hurting. She denied hitting her head. No loss of consciousness. No chest pain or shortness of breath. Resident #1's family member present during exam. No erythematous (red) or bruised joints noted. No joint tenderness over left ankle. Significant knee joint line tenderness on exam and painful range of motion. Mild diffuse left hip discomfort and hip range of motion. Unable to examine the patient's coccyx as she was unable to turn due to left leg discomfort. Sensation in extremities grossly intact and capillary refill normal in toes. Pedal pulses present bilaterally. Lower extremities of equal length, without rotation. Plan: Concerned with patient joint pain, significant weight, and history of injury. Ordering left hip and left knee x-ray as well as sacrum/coccyx x-ray. Non-weightbearing until x-ray results are in. Putting on hold order to change position every 2 hours due to concern of possible fracture. No evidence of neurovascular

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compromise on exam. Continue monitoring. Acetaminophen as needed for pain. Nursing to report if pain not well-controlled.

A review of the physician's orders dated 11/7/23 in Resident #1's medical record indicated the following: coccyx x-ray 2 views, left hip x-ray 2 views, left knee x-ray 2 views to rule out fractures, no weight-bearing until x-ray results are in.

A progress noted dated 11/8/23 by the Medical Director (MD) indicated Resident #1 continues with pain at left knee today. X-ray was ordered, results arrived at noon on 11/8/23 and showed fracture of the distal medial condyle of left femur (inner part of the upper expanded section of the thighbone) with prosthesis noted. She was placed on non-weightbearing status and hold on every two hour positioning order yesterday. Patient is at higher risk for fracture at this site due to prosthesis, female and age over 65 years old. Suspect osteopenia (condition that occurs when the body doesn't make new bone as quickly as it reabsorbs old bone) due to her limited mobility and postmenopausal status. Immediately following review of the results, emergency medical services (EMS) was contacted, and resident transported to emergency department (ED).

Resident #1's hospital discharge summary dated 11/10/23 indicated she was transferred to the hospital on 11/8/23 after presenting for left knee pain after a reported fall at the nursing facility where she resided. Radiographic imaging of the knee demonstrated complex fracture. Computed tomography of left knee showed mildly impacted distal femoral periprosthetic fracture. She was

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admitted to orthopedic surgery with hospital medicine consulting. Initially, they had planned for surgery but ultimately (the Orthopedist) opted for non-operative conservative care due to the patient's underlying medical conditions and baseline mobility limitations. Per family, she was bedbound at baseline and had been for the last three years. Because of her baseline status and the fact that she had no operative needs, she was discharged back to her living facility. May take Ibuprofen and Acetaminophen for pain, as well as ice and elevation for pain and swelling. Non-weightbearing left lower extremity. Wear hinged knee brace on left lower extremity.

Resident #1's November 2023 MAR further indicated that on 11/11/23, she was started on Gabapentin 300 mg by mouth two times a day for pain and on 11/16/23, she received a new medication order for Hydrocodone-Acetaminophen 5-325 mg 2 tablets by mouth every 6 hours as needed for moderate pain.

An interview with Resident #1 on 11/28/23 at 10:41 AM revealed she did not remember what happened, but she remembered having fallen off the bed. Resident #1 stated that she broke her leg, but she was not sure which one. Resident #1 stated her leg hurt whenever they moved her, but she couldn't rate her pain level. She also stated that she was currently working with therapy but did not know how often therapy worked with her. During the interview, Resident #1 kept dozing off after each question.

An observation of personal care on Resident #1 was made on 11/28/23 at 10:53 AM. Resident #1 was lying in bed asleep with her left leg elevated

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on a pillow with a knee immobilizer in place. Resident #1 had soft boots in place on both feet. Although Resident #1 was given a pain medication prior to care, she complained of intermittent pain whenever she was turned and moved in bed. She was observed grimacing and would say "ow, that hurt." She was unable to rate her pain level.

An interview with the Rehabilitation Manager (RM) revealed therapy worked with Resident #1 from July to August 2023 but she only worked with Occupational Therapy (OT) and Speech Therapy. The RM stated that Resident #1 refused an evaluation with Physical Therapy (PT). She stated that Resident #1 was admitted to the facility with a history of a left knee fracture for which she had a prosthesis, so she did not like therapy and did not receive an evaluation from PT because she refused to get up and be moved off her bed. The RM stated that since Resident #1 did not receive a PT screen upon admission to the facility, her transfer status would be obtained from her past medical history. During the interview, the RM pulled up Resident #1's discharge summary from another facility from which she came and noted that Resident #1 was listed as non-ambulatory. The RM stated that using a mechanical lift would be the safest way to transfer Resident #1. She shared that this information was in Resident #1's medical record but she would have to look it up. The RM stated that she found out about Resident #1's fall wherein she obtained a leg fracture, and she did not know how it could have happened. She said that she found out later that a staff member had attempted to transfer Resident #1 without using a mechanical lift. The RM stated that if Resident #1 was attempting to get up from the bed

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unassisted and she witnessed this, she would have called for help from another staff member and educated Resident #1 to stay in bed until they could get a lift because it was not safe to move her without using a mechanical lift. The RM further shared that after Resident #1 came back from the hospital, PT and OT had started working with her, but she had refused three out of five treatments from PT and said that it was painful, and she was not participating. She was not able to state whether she would have had the ability to get herself to sitting position on the side of the bed prior to the incident because PT never worked with her, and they never got her up out of the bed.

An interview with the Medical Director (MD) on 11/29/23 at 12:27 PM revealed the PA was informed that Resident #1 had slid out of chair to the floor, but the MD stated that she did not know that a staff member had attempted to transfer her without using a mechanical lift. The MD stated attempting to let Resident #1 ambulate and stand up possibly led to the fracture on her left leg and this could have been avoided if they had used a mechanical lift on her.

An interview with the Interim Director of Nursing (DON) on 11/29/23 at 11:17 AM revealed during her clinical review on 11/8/23, she noted that Resident #1 had been complaining of pain, so she placed her on the doctor's list to be seen for management of pain. The Interim DON stated clinical review included reading the 24-hour report. Resident #1 was noted to have a fracture on her left knee near her prosthesis, so this was reported to the Administrator, and they started an investigation. The Interim DON stated she only found out about the fall incident when Resident

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#10 was coming back from the hospital on 11/10/23. The Interim DON stated she interviewed the nurse on 11/12/23 and found out that Resident #1 had a fall that was not reported to her, but it was reported to the PA. The Interim DON stated that she was not satisfied with the care approach by NA #1 and when she interviewed him, he stated to her that he didn't know how to care for the resident. He said he did not ask other staff members and attempted to get Resident #1 up without using a mechanical lift. He told her that Resident #1 slid down to her knees when she fell, and he also told her that he didn't know how to transfer Resident #1. The Interim DON stated she had educated NA #1 about where to find information regarding transfer status, but he wasn't receptive, and he would not take responsibility for Resident #1's fall. The Interim DON stated this education was just verbal and she didn't document this anywhere, but she did it before he took his first assignment. The Interim DON stated Resident #1 should have been transferred using a mechanical lift with two staff members assisting. She added that she did not believe that Resident #1 was trying to get out of bed on her own because she did not have trunk control and in order to sit up on the edge of her bed, he must have assisted her to do that. The Interim DON stated the nurse should have filled out an incident report and documented the fall incident in Resident #1's medical record. After she found out about the fall, the Interim DON asked Nurse #1 to fill out an incident report for Resident #1's fall on 11/7/23.

An interview with the Administrator on 11/30/23 at 5:05 PM revealed she learned of Resident #1's fall on 11/7/23 when it was reported at the clinical team meeting. Her initial understanding was that

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F 689	Continued From page 20 it was an injury of unknown origin, and they did not know how the injury occurred. The Interim DON started an investigation which involved talking to the staff members who were involved, and other staff members were working that day. Resident #1 was immediately assessed but she could not say anything about the fall. An x-ray was obtained which revealed a fracture. The Administrator stated when she talked to NA #1, he stated that he had just walked in to the building, and he happened to walk by the room. He immediately tried to assist Resident #1 to the floor. NA #1 told her that he learned from Resident #1's family member that Resident #1 tried to get up all the time, thinking that she could walk. The Administrator stated that NA #1 presented the situation as if he had assisted her from falling on her face and he just intervened. After the Interim DON talked to him, they decided to place him on Do Not Return status on 11/9/23.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		12/7/23

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F 755	Continued From page 21 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews with staff, the Pharmacist and the Medical Director, the facility failed to obtain a controlled pain medication from the pharmacy for 1 of 5 residents (Resident #10) observed for medication administration. The findings included: Resident #10 was admitted to the facility on 3/30/23 with diagnoses that included low back pain and chronic pain syndrome. The Physician's Orders in Resident #10's electronic medical record indicated an active order which started on 11/22/23 for Hydrocodone-Acetaminophen oral tablet 5-325 milligrams (mg) - give 1 tablet by mouth every 6 hours as needed for pain. There was a previous order dated 11/14/23 to 11/21/23 for Hydrocodone-Acetaminophen oral tablet 5-325 mg - give 1 tablet every 8 hours as needed for	F 755	F755 Pharmacy The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	

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F 755	Continued From page 22 pain for 7 days. Resident #10's Medication Administration Record (MAR) for November 2023 from 11/22/23 to 11/29/23 indicated Resident #10 received 12 doses of Hydrocodone-Acetaminophen 5-325 mg tablets. The last dose was given on 11/29/23 at 8:28 PM. During a medication administration observation on Resident #10 by Nurse #4 on 11/29/23 at 8:46 AM, Resident #10 stated to Nurse #4 that he was hurting and wanted his pain medication. Resident #10 stated that he had chronic back pain and that his pain level was at 10. Nurse #4 stated to Resident #10 that he would need to wait a little bit before he got his pain medication because she would need to get another nurse who had access to the automated dispensing cabinet, and she would need to check the last time he received his pain medication. After Nurse #4 left Resident #10's room at 8:50 AM, she checked the MAR and noted it had been over 6 hours since he had received a pain medication so he could get one. Nurse #4 stated that she would need to get another nurse who had access to the automated dispensing cabinet to retrieve the medication for her because she did not have access because she was an agency nurse. She shared Resident #10's Hydrocodone had been ordered from the pharmacy on 11/22/23 but they still hadn't received it at the facility. At 9:08 AM, Nurse #2 and the Assistant Administrator obtained one tablet of Hydrocodone-Acetaminophen 5-325 mg from the automated dispensing cabinet and gave it to Nurse #4. Nurse #2 also gave Nurse #4 the pharmacy's phone number and instructed her to	F 755	On 11/29/23 Nurse # 4 contacted the Physician and a written hard script was sent to the Pharmacy for Resident #10's Hydrocodone-Acetaminophen. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All other residents receiving controlled substance medication have the potential to be affected. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 12/4/23 the Director of Nursing spoke with the Pharmacy and Medical Director to determine what process could be used to ensure hand written scripts were provided by the Physician with each new and/or re-ordered controlled substance medication. The Pharmacy and Medical Director agreed on the following process. This process applies to both new admissions, re-admissions and renewal orders. • The licensed nurse sends the Physician order(s) to the Pharmacy. • Pharmacy will then review the orders and contact the Physician directly to request a hand written script when applicable. • The Physician will respond via "E script". • The staff nurses will contact the Physician if the medication is not received from the Pharmacy.	

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F 755	Continued From page 23 call. Nurse #4 called the pharmacy and found out that they needed to send a new script for the controlled pain medication. Nurse #4 talked to the Director of Nursing and told her about the need to send a script for Resident #10's Hydrocodone. At 9:18 AM, Nurse #4 was observed administering Resident #10's Hydrocodone. An interview with Nurse #4 (agency nurse) on 11/29/23 at 2:37 PM revealed she saw that Resident #10's Hydrocodone had been ordered on 11/22/23 in the electronic MAR but she couldn't see who had ordered it. She did see that the status on the medication was that it was on order. Nurse #4 stated that she had talked to Nurse #5 who worked on the night shift and Nurse #5 told her that if it was ordered on 11/22/23, it should have been delivered to the facility by now. Nurse #4 stated she was not sure if Nurse #5 had followed up with the pharmacy about Resident #10's Hydrocodone but she had not until she was told to do so on 11/29/23. After she talked to the pharmacy, she found out that they didn't have a script for the order which was why they couldn't send it. Nurse #4 stated she was an agency nurse and had only worked at the facility for three shifts. Nurse #4 stated she had given Resident #10 a dose of his Hydrocodone on 11/25/23, 11/28/23 and 11/29/23 and she had to get all of them from the automated dispensing cabinet. Nurse #4 shared that medications could be re-ordered directly from the electronic MAR, but she was not sure where it indicated if a script was needed. An interview with Nurse #5 on 11/30/23 at 8:16 AM revealed Resident #10 often ran out of his	F 755	• Pharmacy will send a report to the Director of Nursing via email weekly for any outstanding controlled substance scripts needed. On 12/5/23 The Director of Nursing and Unit Manager began educating the licensed nurses including (full time, part time, and contract including agency staff) on the process described above. The Nurse Unit Manager/Director of Nursing and Administrator tracked to see what employees had been educated by running an employee listing and as each of them in-serviced the staff, they checked those staff members off the list. Any staff that did not receive the education by 12/7/23 will not be allowed to work until they receive the education. The Nurse Unit Manager and/or Director of Nursing will be responsible for educating these staff members prior to them working. Newly hired employees and agency staff will be educated on the resident's right to be treated and cared for in a respectful and dignified manner during the orientation process. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing and/or Unit Manager and/or designee will review Physician orders for controlled substances and ensure that a hard script has been provided by the Physician and	

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F 755	Continued From page 24 Hydrocodone, and he gets upset because they had to get this medication from the automated dispensing cabinet which takes a long time. Nurse #5 stated it was hard to obtain a controlled medication from the automated dispensing cabinet because two nurses needed to be present and agency nurses were not always given access and even if they were it was only good for 24 hours. Nurse #5 stated she worked for the facility, but she only received access to the automated dispensing cabinet two weeks ago. Nurse #5 further stated that if two nurses who had access were not available on the night shift, she would need to call the Unit Manager and/or the Director of Nursing to have them come in, but the resident would have to wait longer to get his pain medication. Nurse #5 stated that she received report from Nurse #4 on 11/29/23 that Resident #10's Hydrocodone still hadn't come in, but she didn't think of following up with the pharmacy because she had been told that the nurses had been calling, were being told that it was on order and were being advised to just pull from the automated dispensing cabinet. Nurse #5 revealed that she still had to pull the Hydrocodone dose that she gave to Resident #10 on 11/29/23 at 8:30 PM because it didn't get delivered to the facility until 1:00 AM on 11/30/23. She also stated that there were usually 10-12 doses available in the automated dispensing cabinet and she remembered seeing about 5 to 6 doses left when she obtained one on the night of 11/28/23, and there were 4 doses remaining on 11/29/23. A phone interview with the Pharmacist on 11/30/23 at 9:05 AM revealed they had filled Resident #10's order for Hydrocodone the night before and he noted a new order had been	F 755	the script sent/received by Pharmacy. This will be done weekly for 4 weeks then monthly times two months. Audit results will be documented on the audit tool titled “Pharmacy Scripts.” Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Director of Nursing and/or Administrator where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 12-7-2023	

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entered on 11/29/23 at 10:39 AM which was when a new script was sent to them because the directions had changed on the order. It was delivered to the facility on 11/30/23 around 1:00 AM. It was changed from every 8 hours to every 6 hours as needed. He stated that before this, it had been filled last on 11/10/23 when they sent the facility a total of 30 doses. Since it was only given as ordered, the nurses would need to re-order it whenever there were only 6 to 9 tablets left. A new script would be needed whenever it was re-ordered from the pharmacy. The Pharmacist continued to state that they did not receive an order for Resident #10's Hydrocodone on 11/22/23 because they did not receive a script for it. He also stated that the automated dispensing cabinet at the facility was last filled with 10 tablets of Hydrocodone 5-325 mg, and they currently had only 4 doses.

A phone interview with Nurse #6 on 11/30/23 at 1:20 PM revealed she had asked the Medical Director (MD) to renew Resident #10's order for Hydrocodone on 11/22/23 and told her that they needed a new script for this medication. Nurse #6 stated that the MD was doing rounds at the facility at that time, and she received a verbal order from her which she entered into the electronic medical record. Nurse #6 also stated that she even called pharmacy to let them know to be on the lookout for a script from the doctor for Resident #10's Hydrocodone but she couldn't remember who she talked to at the pharmacy.

A phone interview with the MD on 11/30/23 at 1:52 PM revealed that she remembered giving a verbal order to a nurse for Resident #10's Hydrocodone on 11/22/23 but the nurse did not ask her to send a script to the pharmacy. The

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F 755	Continued From page 26 MD stated she normally sent a script when she was notified by nursing because she wouldn't know when they were due or needed. The MD confirmed that she was asked to write a script for Resident #10's Hydrocodone on 11/29/23. An interview with the Director of Nursing (DON) on 11/30/23 at 4:18 PM revealed they had to have a script when ordering narcotics or controlled medications, and these couldn't be re-ordered over the computer. Resident #10's Hydrocodone needed a script before pharmacy could send it to the facility and she was told by the nurses that there was not one and that they had been obtaining his doses from the automated dispensing cabinet. The DON stated she always asked the nurses whether all medications were available in their cart and had told them that whenever they couldn't find a medication to contact her, and she would call the provider to get a script if it was a controlled medication. The DON stated she was not aware that they had been using the automated dispenser for a week for Resident #10's Hydrocodone. Agency nurses were provided 24-hour access to the automated dispensing cabinet and were educated about the process for re-ordering controlled substances before they start working at the facility.	F 755		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the	F 867		12/7/23

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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, and track performance to ensure that

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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 and complexity of the facility's services and

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F 867	Continued From page 29 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 and staff interview, 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 surveys conducted on 4/29/21 and 1/20/23 and the complaint investigation surveys conducted on 6/7/23, 10/18/23 and 11/21/23. This was for four repeat deficiencies that were cited in the areas of resident rights, accident hazards, pharmacy services and infection control. Accident hazards was originally cited on 1/20/23 during the	F 867	F867 QAPI/QAA Improvement Activities Components utilized to ensure that these alleged deficient practices do not recur include: Quality assurance monitoring, physician reviews, consultant reviews and staff training. The facility will also continue to utilize outside consulting services for ongoing clinical support and monitoring oversight of the citations. On 12/4/23 the Administrator contacted the Quality Improvement Organization (QIO) with the State Quality Monitoring by	

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F 867	Continued From page 30 recertification survey, and subsequently recited during two complaint investigation surveys completed on 11/21/23 and 11/30/23. Pharmacy services was originally cited on 4/29/21 during the recertification survey, and subsequently recited during two complaint investigation surveys completed on 6/7/23 and 11/30/23. Resident rights and infection control were originally cited on 10/18/23 during a complaint investigation survey, and subsequently recited during another complaint investigation survey completed on 11/30/23. The continued failure of the facility during six federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F 550 - Based on record review, resident and staff interviews, the facility failed to treat a resident with dignity when Nurse Aide (NA) #1 adjusted Resident #8 down in the bed by his ankles when the resident asked to be moved down in the bed for 1 of 3 residents reviewed for dignity (Resident #8). During the complaint investigation survey on 10/18/23, the facility failed to treat a resident in a respectful and dignified manner when the Social Worker completed a Brief Interview for Mental Status (BIMS) assessment on 1 of 3 residents reviewed for dignity and respect. This occurred while he was in the therapy gym with other residents and therapists in the same area of the gym. The resident stated it made him feel "embarrassed, singled out, and targeted."	F 867	email to enlist facility Quality Improvement support. On 12/5/23 the Administrator, Director of Nursing, Nurse Unit Manager, and Contracted Clinical Nurse Consultants reviewed the survey findings for the repeat deficiencies F550, F689, F755 and F880 and developed monitoring tools for each cited deficiency as part of the plan of correction developed. On 12/5/23 the Administrator held a meeting with Department Managers consisting of (Director of Nursing, Nurse Unit Managers, Director of Social Work, Director of Rehabilitation, Administrative Assistant, Activities Director, Minimum Data Set (MDS), Environmental Director, Central Supply Director, and the Dietary Manager to review the survey findings and plans of corrections for the areas of concern. On 12/5/23 education was provided by the Administrator to the Department Managers on the monitoring of identified areas of concern and the responsibilities for monitoring corrective plans and actions. On 12/6/23 the Administrator implemented the following continued monitoring measures: a) The monitoring results for all areas that received a citation will be discussed in morning meetings to ensure corrective measures are effective, b) Ad hoc quality assurance discussion will occur weekly to discuss monitoring results and to make process revisions if corrective measures are not effective and	

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F 867	Continued From page 31 F 689 - Based on record review, observation, and interviews with resident, staff, and the Medical Director, the facility failed to use a mechanical lift to transfer a non-ambulatory resident (Resident #1) for 1 of 3 residents reviewed for accidents. Resident #1 sustained a distal femoral periprosthetic (structure in close relation to an implant) fracture of the left knee after Nurse Aide #1 attempted to transfer her from bed to wheelchair by putting his hands on her and supporting her by holding the back of her pants after her knees buckled as soon as she stood up. During the complaint investigation survey on 11/21/23, the facility failed to prevent a resident with severe cognitive impairment and a history of wandering and exit-seeking behaviors, from exiting the facility unsupervised and without staff knowledge. During the recertification and complaint survey on 1/20/23, the facility failed to conduct smoking assessment periodically. F 755 - Based on record review, observation and interviews with staff, the Pharmacist and the Medical Director, the facility failed to obtain a controlled pain medication from the pharmacy for 1 of 5 residents (Resident #10) observed for medication administration. During the complaint survey on 6/7/23, the facility failed to acquire medications ordered for administration resulting in multiple doses of the prescribed medication being missed. During the recertification and complaint survey on 4/29/21, the facility failed to have two nurses, or a nurse and a medication aide sign the narcotic	F 867	c) the monitoring results will also be reported to the Quality Assurance and Process Improvement Committee monthly for no less than 3 months. The Quality Assurance and Process Improvement Committee will then determine if continued monitoring is needed and/or if modifications to the action plan is needed to ensure continued compliance. On 12/6/23 the Administrator revised the Quality Assurance and Process Improvement Committee agenda to reflect the new cited deficiencies and monitoring. Completion date: 12/7/23	

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F 867	Continued From page 32 count card. F 880 - Based on observation, record review, and staff interviews, the facility failed to implement their infection control policy when Nurse #2 did not perform hand hygiene after removing a soiled dressing with drainage on it and before donning new gloves to cleanse the wound with wound cleanser-soaked gauze. Nurse #2 also failed to perform hand hygiene after cleaning scissors with alcohol, doffing gloves and before donning new gloves to continue with care for 1 of 1 resident (Resident #4) reviewed for wound care. During the complaint survey on 10/18/23, the facility failed to implement their infection control policy when a nurse did not perform hand hygiene after removing a soiled dressing with drainage on it and before donning new gloves to cleanse the wound with saline-soaked gauze. An interview with the Administrator on 11/30/23 at 5:30 PM revealed Nurse #2 was nervous, and she was being human. Nurse #2 had been audited twice by their contracted regional nurses and both reported that she did a great job, and they didn't have any concerns with their wound care observations. The Administrator stated that she wished they could ensure that no resident would fall, elope or have an incident. The Administrator stated that they had always had issues with the pharmacy and they got a different answer depending on who they talked to at the pharmacy.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		12/7/23

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	345302	A. BUILDING _____ B. WING _____	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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F 880	Continued From page 33	F 880		

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 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

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F 880	Continued From page 34 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 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 observation, record review, and staff interviews, the facility failed to implement their infection control policy when Nurse #2 did not perform hand hygiene after removing a soiled dressing with drainage on it and before donning new gloves to cleanse the wound with wound cleanser-soaked gauze. Nurse #2 also failed to perform hand hygiene after cleaning scissors with alcohol, doffing gloves and before donning new gloves to continue with care for 1 of 1 resident (Resident #4) reviewed for wound care. The findings included:	F 880	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be	

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F 880	Continued From page 35 The facility's policy entitled Handwashing/Hand Hygiene which is part of their Infection Control Policies and Procedures last revised on 08/2014 under Policy Interpretation and Implementation read in part: 7. Use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or alternatively, soap and water for the following situations: a. Before and after direct contact with residents; g. Before handling clean or soiled dressings, gauze pads, etc.; k. After handling used dressings, contaminated equipment, etc.; m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. An observation of wound care by Nurse #2 was made on 11/29/23 at 10:50 AM. Nurse #2 washed her hands with soap and water and donned clean gloves. The resident was sitting in his wheelchair with his left leg dependent and his left foot resting on a towel on the floor. Nurse #2, using her scissors, removed the old dressing which had a moderate amount of serous drainage on the dressing. With the same gloves on she proceeded to cleanse the wound with wound cleanser-soaked gauze and repeated the process to get the calcium alginate (a water-insoluble, gelatinous cream-colored substance used for granulating phase of wound repair) out of the wound bed. After removing the calcium alginate	F 880	completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #4 did not have any adverse effects from the Nurse not performing hand hygiene after removing the soiled dressing and before donning new gloves to clean the wound on 11/29/23. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with current wounds have the potential to be affected. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Nurse #2 was verbally counseled by the Director of Nursing on 11/30/2023 on how to perform hand hygiene while providing wound care. On 12/4/23, the Director of Nursing developed a “cheat sheet” outlining the step-by-step procedure for Handwashing and Hand Hygiene while performing wound care. The steps included are: • Use an alcohol-based hand rub (ABHR) or soap and water for handwashing: • BEFORE and AFTER direct contact with residents	

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F 880	Continued From page 36 she cleansed the wound again and with clean gauze patted the wound dry. Nurse #2 then doffed her gloves, washed her hands with soap and water, and donned clean gloves and cleaned her scissors which she had used to remove the resident's soiled dressing with an alcohol wipe. She then doffed her gloves and donned a clear pair of gloves without sanitizing her hands and proceeded to apply new calcium alginate in the wound bed, covered with an ABD (abdominal gauze pad used to absorb discharge from heavily draining wounds) pad, wrapped with kerlix (bandage roll that provides fast-wicking action, aeration and absorbency to cushion and protect wound areas), and secured with tape with her initials and date. Nurse #2 doffed her gloves and without sanitizing her hands collected her supplies and left the room. An interview on 11/29/23 at 3:30 PM with Nurse #2 revealed she thought the wound care for Resident #4 had gone well. She stated she had education recently on proper handwashing and proper procedure for dressing changes and stated she had been monitored by nursing management on dressing changes. When discussing the dressing change, she initially stated that she didn't need to doff her gloves, sanitize her hands, and don new gloves before cleaning the wound because it was considered "dirty." As the discussion continued and she reviewed the handwashing policy and the dressing procedure she realized she needed to have sanitized her hands and donned new gloves before cleaning the wound bed. Additionally, as she reviewed the policies, she realized she should have sanitized her hands after cleaning her scissors and doffing her gloves and before donning new gloves. Nurse #2 further stated it	F 880	• BEFORE handling clean or soiled dressings • AFTER handling used dressings, contaminated equipment, etc. • AFER removing gloves The “cheat sheet” will be placed on treatment cart for nurses to use as a guide prior to completing wound care. Beginning on 12/4/23 a second licensed nurse will accompany the licensed nurse performing the wound care to remind the nurse to follow the steps outlined above. On 12/4/23 the Administrator notified the Director of Nursing, Infection Preventionist or designee on the need to educate the licensed nurses including (full time, part time, and contract including agency staff) on the need to provide the following education: a) performing hand hygiene after the removal of the existing dressing and before donning new gloves to clean/re-dress the wound, b) the implementation of the “cheat sheet” and c) notifying a second license nurse to accompany them while performing wound care. On 12/4/23 the Director of Nursing, Infection Preventionist or designee began educating the licensed nursing staff. Any Licensed Nurses that did not receive the education by 12/4/23 will not be allowed to work until they receive the education. The Nurse Unit Manager and/or Director of Nursing will be responsible for educating these staff members prior to them working.	

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F 880	Continued From page 37 was not because she had not been educated and monitored because she had been and said it was her mistake that it had not been done correctly. An interview on 11/30/23 at 4:29 PM with the interim Director of Nursing (DON) revealed she had educated Nurse #2 herself on proper handwashing and dressing changes and did not understand why she had not done the dressing change correctly. The DON stated she had given Nurse #2 the policy before she went into Resident #4's room to perform the dressing change and stressed to her to slow down, take her time and if she needed to stop and think before proceeding, she could certainly take the time to do so. She further stated some nurses were just more proficient than others and she would have to figure out what to do differently to help Nurse #2 be successful. An interview on 11/30/23 at 5:17 PM with the Administrator revealed they had discussed the education and monitoring they had done to help the nurses to be successful and said they would just have to put Nurse #2 and the other nurses through these processes daily and monitor more closely going forward. The Administrator also stressed she thought Nurse #2 was just nervous having others watching her do the dressing change and they would work with her to make her more comfortable.	F 880	Newly hired Licensed Nurses and agency Licensed Nurses will be educated during orientation on the educational material outlined above. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing, Nurse Consultant or designee will observe wound care for 3 residents weekly for 4 weeks and then 3 residents monthly for 2 months to ensure the Licensed Nurse performs hand hygiene during wound care according to facility policy. Audit results will be documented on the audit tool titled Hand Hygiene during Wound care. Results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Director of Nursing and/or Administrator where they will be reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 12-7-2023	