STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. BUILDING _____ B. WING _____	C 12/22/2023

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MACGREGOR DOWNS HEALTH CENTER BY HARBORVIEW	2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834

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E 000	Initial Comments The survey team entered the facility on 12/17/23 to conduct a recertification survey and complaint investigation. The survey team was onsite 12/17/23 through 12/20/23. Additional information was obtained offsite on 12/21/23 and 12/22/23. Therefore, the exit date was 12/22/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #63YK11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 12/17/23 to conduct a recertification survey and complaint investigation. The survey team was onsite 12/17/23 through 12/20/23. Additional information was obtained offsite on 12/21/23 and 12/22/23. Therefore, the exit date was changed to 12/22/23. Event ID# 63YK11. The following intakes were investigated NC00205089, NC00204376, NC00203711, NC00211045, NC00210888 and NC00207605. 3 of the 14 complaint allegations resulted in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		1/24/24

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

Electronically Signed | 01/21/2024

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff,	F 580	F-580 Notify of Changes	

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F 580	Continued From page 2 resident, nurse practitioner, and podiatrist interviews, the facility failed to notify the resident's physician of a change in condition for 1 of 1 resident (Resident #118) reviewed for Notification of Changes. Resident #118 experienced bleeding following the debridement of her right great toenail. This change in condition was not reported to the resident's attending Physician or the Podiatrist. Findings included: Resident # 118 was admitted to the facility on 5/5/23 with a diagnosis that included type 2 diabetes with neuropathy, and chronic kidney disease (CKD) stage 3. Review of podiatry visit summary and progress notes dated 12/6/23 revealed that Resident #118 had a podiatric diagnosis of atherosclerosis (a thickening or hardening of the arteries) of the extremities, onychomycosis (fungal infection of the nail unit); type 2 diabetes mellitus with peripheral circulation disorders. Resident #118 was evaluated, examined, and treated at bedside. The note further the toenails were debrided without incident. No signs of infection were noted. The nails were debrided by manual method. On 12/17/23 at 1:57 PM an interview with Resident #118 revealed she was concerned about a wound on her right great toe from where the Podiatrist cut her toenails recently. She stated she was diabetic and was concerned it would get infected. Resident #118 stated that she did not notice the wound right away because she had no feeling in her feet, so it did not hurt. Resident #118 stated it was a family member that first noticed blood on her sock over the right great toe when she visited the following day (12/7/23) and	F 580	1. Immediate action taken for residents found to have been affected: Nurse provided care to resident once area was identified by Resident Representative. Facility also reached out to resident's podiatrist for follow-up. 2. Identification of other residents having the potential to be affected: All residents have the potential to be affected. 3. Actions taken/systems put into place to reduce risk of further occurrences: Director of Nursing educated licensed nursing staff on reporting change of conditions to Physican and completing proper notifications to resident representatives and other necessary staff. Education will be completed for current staff by 1/24/24. All newly hired licensed nursing staff will be educated on reporting changes of condition by the Staff Development Coordinator or ADON. Facility treatment nurse, Director of Nursing and Assistant Director of Nursing completed skin audits on all residents seen by Podiatry in the last 3 months. No additional concerns were noted. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: In clinical start up that occurs daily, all changes of condition will be monitored by auditing SBARs and alert charting to ensure proper communication was made to Physician and Resident RP if	

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F 580	Continued From page 3 notified staff and they cleaned it and put an adhesive bandage on her toe. She did not recall the name of the staff that was notified. In a phone interview with Nurse #2 on 12/19/23 at 8:43 AM it was revealed that Nurse #2 was familiar with and assigned to Resident #118 when on duty. Nurse #2 indicated that the podiatry clinic was held on Tuesday 12/5/23 or Wednesday 12/6/23 and she next saw the resident on Thursday 12/7/23 or Friday 12/8/23. She further indicated that when she saw Resident #118 that there was an adhesive bandage on her right great toe that had residual dried blood on it, so she cleaned it and left it open to air, so it would not get infected. She stated there was also dried blood noted on the right great toe of Resident #118 and you could see the indentation of where the cut toenail had previously been, but the tissue looked healthy. Nurse #2 indicated that when the family member of Resident #118 came and asked about her toe on 12/7/23 or 12/8/23 that she went to the room with the family member, looked at the toe together and removed the adhesive bandage and showed her that it was clean and there was no swelling or odor, but the nail was noticeably cut too short. On 12/21/23 at 9:58 AM in a phone interview with the facility contract Podiatrist it was revealed that he recalled providing podiatry services of toenail debridement (trimming) to Resident #118 on 12/6/23 at the facility. He reported that Resident #118 was a poorly controlled diabetic with poor circulation and had weak pulses to the lower extremities, had chronic kidney disease, fungal toenails and a poor immune system placing her at high risk for infection. The Podiatrist further indicated Resident #118 had on blue nail polish	F 580	applicable. DON/ADON will audit 5 days a week x 4 weeks, 3 days a week x 2 weeks and 1 time a week for 1 week. Any deficiencies found with the Audits will be corrected immediately and re-education done as necessary by the DON. The DON will review and discuss Audit results in the QAPI meeting monthly for 3 months. Corrective action completion date: 1/24/24	

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F 580	Continued From page 4 and that nail polish can harbor infection further increasing her risk for infection. He did not recall cutting her nails too short and did not notice blood at the time. The interview further revealed that bleeding can occur later after nail debridement, and it was not uncommon for a patient with her diagnosis. He stated that she was on low dose aspirin and that would cause bleeding to be present longer. He indicated that when the nurse noted that the area had bled that she should have cleaned the toe, applied antibiotic ointment, and covered it with a band aid and then should have notified the on-call podiatrist for further instructions.	F 580		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, family, responsible party, and police detective interviews the facility failed to prevent misappropriation of resident property when a nurse aide (NA #8) took resident's credit cards and used them without permission to make purchases. This was for 2 of 2 residents (Resident #286 and Resident #12) reviewed for misappropriation. Findings included:	F 602	F602-Free from Misappropriation Immediate action(s) taken for the resident(s) found to have been affected include: An investigation was concluded after both residents and their families had determined that their credit cards had been compromised. The investigation was inconclusive in determining how the	1/24/24

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F 602	Continued From page 5 1. Resident #286 was admitted to the facility on 4/13/23 with a diagnosis of right femur (leg bone) fracture. A review of Resident #286's admission Minimum Data Set (MDS) assessment dated 4/20/23 revealed she was cognitively intact. A review of the facility's initial allegation report dated 4/25/23 revealed in part Resident #286's Responsible Party (RP) notified the Administrator on 4/25/23 at 2:00 PM that when he was paying Resident #286's credit card bill he noticed fraudulent charges. The RP reported the fraudulent charges began on 4/15/23 and the most recent one on the billing statement was on 4/19/23. He further reported Resident #286 had the physical card in her possession, but it was now bent. The facility notified law enforcement on 4/25/23 at 2:30 PM. A review of the facility's investigational summary dated 4/25/23 revealed in part Resident #286 and her family denied seeing anyone take Resident #286's credit card. Resident #286 had the physical credit card in her possession, but it was bent now and had not been bent before. The Administrator notified law enforcement but had been told that due to the police policy on credit card fraud, Resident #286's family would first have to contact the credit card company and obtain an affidavit (a legal sworn witnessed statement) or confirmation of the fraudulent charges before an officer could be sent. The Administrator and Director of Nursing (DON) interviewed all staff that worked with Resident #286 at the time of the fraudulent charges. All staff denied seeing or hearing anything regarding the incident. All staff denied any involvement in	F 602	fraudulent charges were made since the residents had not witnessed anyone take cards from their room nor had anyone else witnessed any theft. Residents and resident families are encouraged upon admission to send home any valuables or items of value that are not needed for their stay with a trusted family member. Both residents decided to keep these items in their rooms. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Alert and oriented residents on these halls were interviewed concerning missing money or belongings with no concerns noted. Staff members who worked on the halls where the credit cards had been taken were interviewed to see if they had noticed anyone going through resident belongings or any other suspicious activity. No concerns were made. Actions taken/systems put into place to reduce the risk of future occurrence include: During both investigations, Abuse/Neglect education was conducted with staff to ensure staff were made aware of the proper process for reporting	

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F 602	Continued From page 6 the incident. Residents residing on the same hall as Resident #286 were randomly interviewed regarding any concerns during their stay so far in the facility. These residents denied any concerns. The DON initiated in-servicing with staff regarding misappropriation of resident's property. A review of a Greenville North Carolina (NC) police report dated 5/9/23 revealed in part Resident #286's RP reported he discovered fraudulent charges on Resident #286's credit card bill. There was no way Resident #286 could have made the purchases herself as she had not left the facility since her admission on 4/13/23. Resident #286 had never noticed her credit card missing as it had been in her purse every morning when she verified that it was there. There were several charges on the card from the surrounding areas totaling $1425.85. Resident #286's credit card had been cancelled, and the credit card company refunded the stolen money. Resident #286's RP had Power of Attorney to protect Resident #286 against any further theft. Resident #286's RP provided an affidavit for the fraudulent credit card charges. A review of the Greenville NC police case supplemental report dated 5/17/23 written by Investigator #1 revealed in part on 5/12/23 after reviewing Resident #286's credit card account activity he responded to the businesses where the card transactions occurred. Investigator #1 was able to view video surveillance footage at several of these businesses and confirm that the same female suspect was identified making the transactions. Investigator #1 obtained a picture of this suspect and brought it back to the facility's Human Resources Director for identification. The Human Resources Director identified the suspect	F 602	Abuse/Neglect or Misappropriation of resident property. All new Staff will be in serviced on these items and policies during the orientation process by the Director of Human Resources or Staff Development Coordinator. All current staff will be re-educated on policies and procedures for Abuse, Neglect and Misappropriation of resident property. Any staff who has not gone through the training prior to the compliance date will have to do so prior to working again. We have no outside agency staff at this time. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator or Director of Nursing will conduct a random interview of 10 residents weekly for 4 weeks, 15 resident’s biweekly for 2 months and then 20 residents monthly for 2 months. These residents will be interviewed about possible abuse that they have experienced including misappropriation of funds. Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the Administrator as appropriate.	

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F 602	Continued From page 7 as Nurse Aide (NA) #8. The Human Resources Director reported NA #8 had been working at the facility during the time the charges were made but she had been terminated on 5/3/23 for unrelated reasons. On 5/17/23 Investigator #1 secured an arrest warrant for NA #8 for 1 count of financial card theft and 7 counts of obtaining property under false pretenses for the incidents. On 12/19/23 a review of NA #8's employee file revealed her hire date was 2/28/22. It further revealed her employment was terminated on 5/4/23. NA #8's last day worked at the facility was 5/2/23. She was not eligible for rehire. On 12/19/23 at 9:50 AM an interview with the Administrator indicated she initiated the facility investigation of this incident on 4/25/23. She stated staff who were working on the same assignment at the time the charges occurred were interviewed to determine if they had seen or heard anything suspicious and written statements were obtained. She went on to say no staff indicated they had seen or heard anything suspicious. She stated Social Worker #2 had interviewed alert and oriented residents who resided on the same hall as Resident #286 at the time of the incident. She went on to say no other residents reported any concerns. The Administrator stated in-service education had been provided to staff regarding misappropriation of resident property after the incident. She went on to say initially, the police would not come out to do an investigation until Resident #286's family got a statement from the credit card company. She further indicated by the time the investigator brought the picture of NA #8 to the Human Resources Director for identification, NA #8's employment with the facility had already been	F 602	The audit findings will be reported by the Administrator in a Monthly QAPI meeting for a minimum of 3 months. Corrective action completion date: 1/24/24.	

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terminated for attendance issues.

On 12/19/23 at 10:55 AM an attempt at telephone interview with NA #8 revealed the phone number provided by the facility was no longer in service. There were no other contact numbers for NA #8.

On 12/19/23 at 1:04 PM a telephone interview with Investigator #1 indicated he viewed video surveillance footage at multiple businesses for the date and time Resident #286's credit card was used. He stated he brought a photo from the footage back to the facility and the Human Resources Director identified the suspect as NA #8. He went on to say based on this evidence, an arrest warrant had been issued for NA #8 for the incidents.

On 12/19/23 at 2:38 PM a telephone interview with Resident #286's RP indicated Resident #286 brought her credit card with her to the facility when she was admitted there on 4/13/23. He stated an employee at the facility stole Resident #286's credit card and used it to make fraudulent purchases. He went on to say thankfully that employee had been caught. He further indicated Resident #286 had not suffered any financial hardship as a result of the theft and she was not charged for the fraudulent charges by the credit card company.

On 12/20/23 at 10:15 AM an interview with the DON indicated she provided staff in-service education related specifically to stealing from residents on 4/27/23 and on 5/22/23 regarding misappropriation. During a review of these in-service education attendance forms with the DON she stated neither in-service attendance form included all staff.

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On 12/20/23 at 10:55 AM in an interview the Human Resources Director confirmed she was able to identify NA #8 when Investigator #1 showed her the picture of the suspect.

2. Resident #12 was admitted to the facility on 3/16/23 with a diagnosis of cerebrovascular disease.

A review of Resident #12's admission Minimum Data Set (MDS) assessment dated 3/23/23 revealed she was cognitively intact.

A review of the facility's initial allegation report dated 6/19/23 revealed in part on 6/19/23 Resident #12's family member reported to the facility that a fraudulent charge made on 4/21/23 had shown up on Resident #12's credit card statement. Resident #12's family member had gone through Resident #12's personal belongings and discovered her credit card was missing. The Greenville North Carolina (NC) police were notified.

A review of the facility's investigational summary dated 6/19/23 revealed in part that on 6/19/23 the Administrator contacted Resident #12's family member to discuss her concerns with a fraudulent charge made with Resident #12's credit card on 4/21/23. The Administrator advised Resident #12's family member that law enforcement would not typically take a police report for fraudulent charges without an affidavit (a legal sworn witnessed statement) from the credit card company confirming the charges were made fraudulently. Resident #12 was confused and was not able to be interviewed. Resident #12's family member told the Administrator she

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asked Resident #12 about the missing credit card and Resident #12 had not been able to give much information due to her confusion. Statements were collected from staff that worked with Resident #12 from 4/20/23 to 4/22/23. No issues were reported. Interviews with alert and oriented residents related to resident's rights and resident's belongings were conducted. No issues were reported. Staff had been in-serviced on resident's rights and misappropriation of resident property. It was further revealed on 6/23/23 the Administrator reached back out to Resident #12's family to update her on the progress of the investigation. Nurse Aide (NA) #8's employment with the facility had been terminated on 5/4/23 due to attendance issues. NA #8 was connected to a different allegation of misappropriation of resident property that occurred on 4/15/23. NA #8 was identified by the facility for the Greenville NC Police Department on 5/12/23. NA #8 was found to have worked on Resident #12's assignment on 4/20/23, the day before the fraudulent charge was placed.

A review of the Greenville NC police report dated 9/27/23 written by Greenville NC Police Investigator #1 revealed in part Resident #12 had been under the care of NA #8 at the facility. On 4/21/23 a charge of $350.46 was made at a business with Resident #12's credit card. Investigator #1 had investigated a similar case at the same facility during the same time frame where NA #8 had been charged with 1 count of financial card theft and 7 counts of obtaining property under false pretenses for those incidents. What was significant was that Resident #12's credit card was used at one of the same businesses involved in the previous case. Investigator #1 was waiting to see if he could

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obtain video footage from this business. A supplemental entry to this police report dated 11/27/23 revealed Investigator #1 had not been able to obtain video footage for the incident from the business. Due to circumstances surrounding the case, probable cause existed, and a warrant was secured for the arrest of NA #8 for 1 count of financial card theft and 1 count of obtaining property under false pretenses in Resident #12's case.

On 12/17/23 at 2:05 PM an interview with Resident #12 indicated she had an issue when she was first admitted to the facility with a staff member stealing her things, but this had been resolved by the facility.

On 12/19/23 a review of NA #8's employee file revealed her hire date was 2/28/22. It further revealed her employment was terminated on 5/4/23. NA #8's last day worked at the facility was 5/2/23. She was not eligible for rehire.

On 12/19/23 at 9:50 AM an interview with the Administrator indicated she initiated the facility investigation of this incident on 6/19/23. She stated staff who were working on the same assignment at the time the credit card charge occurred were interviewed to determine if they had seen or heard anything suspicious and written statements were obtained. She went on to say no staff indicated they had seen or heard anything suspicious. She stated Social Worker #2 had interviewed alert and oriented residents who resided on the same hall as Resident #12 at the time of the incident. She went on to say no other residents reported any concerns. The Administrator stated family members of cognitively impaired residents had not been

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interviewed regarding any missing property or unrecognized credit card charges. The Administrator stated in-service education had been provided to staff regarding misappropriation of resident property. She further indicated by the time the investigator brought the picture of NA #8 to the Human Resources Director for identification, NA #8's employment with the facility had already been terminated for attendance issues. She stated after this second allegation, she provided an update to the Health Care Personnel Registry regarding NA #8, asked if she needed to do a new investigation, and was told she did not.

On 12/19/23 at 10:37 AM a telephone interview with Social Worker (SW) #2 indicated she recalled participating in an investigation regarding misappropriation of resident property. She stated she recalled this being for Resident #286. She went on to say she had interviewed alert and oriented residents on whether they had observed anything suspicious. She stated she did not recall interviewing families of any cognitively impaired residents. She went on to say she did not recall doing this again for Resident #12.

On 12/19/23 at 10:55 AM an attempt at telephone interview with NA #8 revealed the phone number provided by the facility was no longer in service. There were no other contact numbers for NA #8.

On 12/19/23 at 12:06 PM a telephone interview with Resident #12's family member indicated Resident #12 had her credit card with her when she was admitted to the facility. She stated Resident #12 had not used her credit card for over a year. She went on to say she got a bill from the credit card company for over $300.00

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and knew that it had to be fraudulent. She further indicated she had immediately called the credit card company, cancelled the card, and gone to the facility to find out what happened. She stated when she got to the facility, she realized Resident #12's credit card was missing from her purse. She stated the police had been notified, and although she had never gotten the credit card back, the credit card company had not billed Resident #12 for the charges. Resident #12's family member stated Resident #12 had not experienced any financial hardship as a result of the fraudulent charges.

On 12/19/23 at 1:04 PM a telephone interview with Investigator #1 indicated he investigated another case involving a resident of the same facility previously. He stated in that case he viewed video surveillance footage at multiple businesses for the date and time the resident's credit card was used. He stated he brought a photo from the footage back to the facility and the Human Resources Director identified the suspect as NA #8. He went on to say based on this evidence, an arrest warrant for NA #8 for those incidents. He further indicated although he was not able to view video footage for the case involving Resident #12, because Resident #12's credit card was used at one of the same businesses, he had probable cause to obtain an arrest warrant for NA #8 in Resident #12's case as well.

On 12/20/23 at 10:15 AM an interview with the DON indicated she provided staff in-service education related specifically to stealing from residents on 4/27/23 and on 5/22/23 regarding misappropriation. During a review of these in-service education attendance forms with the

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F 602	Continued From page 14 DON she stated neither in-service attendance form included all staff. On 12/20/23 at 10:55 AM in an interview the Human Resources Director confirmed she was able to identify NA #8 when Investigator #1 showed her the picture of the suspect.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and	F 607		1/24/24

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F 607	Continued From page 15 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and, staff, family, responsible party, and police detective interviews the facility failed to implement their abuse policy and procedure by failing to maintain evidence of proof of preemployment screening and failing to maintain documentation of a complete and thorough investigation of allegations of misappropriation. This was for 2 of 2 residents (Resident #286 and Resident #12) reviewed for misappropriation. Findings included: A review of the facility policy titled "Abuse, Neglect and Exploitation" last revised 6/1/23 revealed in part, "It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The components of the facility abuse prohibition plan are discussed herein: 1. Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. 2. Screenings may be conducted by the facility itself, third party agency, or academic institution. 3. The facility will maintain documentation of proof that the screening occurred. V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of	F 607	F-607 Abuse and Neglect Policies 1. Immediate action(s) taken for the resident(s) found to have been affected include: • An investigation was conducted for each of the two resident's whose credit cards had been misappropriated. The facility was not able to substantiate any allegations during the investigation due to neither resident having witnessed their property being taken nor had any suspicions on who might have taken it. Staff were interviewed as well with no concerns noted. Both residents were awarded back the funds that had been charged on the credit cards by the credit card company with no financial hardship. 2. Identification of other residents having the potential to be affected was accomplished by: • The facility has determined that all residents have the potential to be affected. • During both investigations, alert and oriented residents residing on the hall where the misappropriation took place were interviewed concerning missing property. No concerns were noted. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • During both investigations,	

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F 607	Continued From page 16 abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 6. Providing complete and thorough documentation of the investigation." 1. Resident #286 was admitted to the facility on 4/13/23 with a diagnosis of right femur (leg bone) fracture. A review of Resident #286's admission Minimum Data Set (MDS) assessment dated 4/20/23 revealed she was cognitively intact. A review of the facility's initial allegation report dated 4/25/23 revealed in part Resident #286's Responsible Party (RP) notified the Administrator on 4/25/23 at 2:00 PM that when he was paying Resident #286's credit card bill he noticed fraudulent charges. The RP reported the fraudulent charges began on 4/15/23 and the most recent one on the billing statement was on 4/19/23. He further reported Resident #286 had the physical card in her possession, but it was now bent. The facility notified law enforcement on 4/25/23 at 2:30 PM. A review of the Greenville NC police case supplemental report dated 5/17/23 written by Investigator #1 revealed in part on 5/12/23 after reviewing Resident #286's credit card account activity he responded to the businesses where the card transactions occurred. Investigator #1 was able to view video surveillance footage at several of these businesses and confirm that the same female suspect was identified making the transactions. Investigator #1 obtained a picture of this suspect and brought it back to the facility's Human Resources Director for identification. The	F 607	Abuse/Neglect education was conducted with all staff to ensure all staff were made aware of the proper process for reporting Abuse/Neglect or Misappropriation of resident property. • All new Staff will be in serviced on these items and policies during the orientation process by the Director of Human Resources or Staff Development Coordinator. • All current staff will be re-educated on policies and procedures for Abuse, Neglect and Misappropriation of resident property. Any staff who has not gone through the training prior to the compliance date will have to do so prior to working again. • The Administrator will maintain all investigation documentation and audit all investigations to ensure all required evidence of a thorough investigation has been conducted. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • The Director of Human Resources will audit all current licensed employee records to ensure all required preemployment documentation is present. If any documentation is not present during the audit, the Director of Human Resources will complete and place in employee's file. • The Administrator or Director of Nursing will conduct audits on all new employee files prior to orientation to ensure all required documentation is in place and in the employee record. The	

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F 607	Continued From page 17 Human Resources Director identified the suspect as Nurse Aide (NA) #8. The Human Resources Director reported NA #8 had been working at the facility during the time the charges were made but she had been terminated on 5/3/23 for unrelated reasons. It was further revealed on 5/17/23 Investigator #1 secured an arrest warrant for NA #8 for 1 count of financial card theft and 7 counts of obtaining property under false pretenses for the incidents. On 12/19/23 a review of NA #8's employee file revealed her hire date was 2/28/22. There was no evidence of a preemployment criminal background check or preemployment Nurse Aide Registry check. On 12/19/23 at 9:50 AM an interview with the Administrator indicated she initiated the facility investigation of this incident on 4/25/23. She stated staff who were working on the same assignment at the time the charges occurred were interviewed to determine if they had seen or heard anything suspicious and written statements were obtained. She went on to say she did not know what happened to the written statements as they were not in the investigation folder. The Administrator stated she thought they must have been taken by the police investigator. She stated Social Worker #2 had interviewed alert and oriented residents who resided on the same hall as Resident #286 at the time of the incident. She further indicated she did not know why there was no documentation of these resident interviews in the facility's investigation of the incident. At 3:00 PM a follow-up interview with the Administrator indicated she did not know why there was no record of NA #8's preemployment criminal background check or preemployment Nurse Aide	F 607	Administrator or Director of Nursing will audit these items once a week times 4 weeks, bi-weekly for 2 months and monthly times 2 months. • Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the Administrator as appropriate. • The Audit findings will be reported by the Administrator in a Monthly QAPI meeting for a minimum of 3 months. Corrective action completion date: 1/24/24.	

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Registry check in the facility investigation. She stated the facility required these when NA #8 was hired. She went on to say she knew these had been done because she had seen them. She further indicated NA #8 had nothing on her preemployment criminal background check and no findings against her on her preemployment Nurse Aide Registry check, but she did not know where the documents had gone.

On 12/19/23 at 1:04 PM a telephone interview with Investigator #1 indicated he viewed video surveillance footage at multiple businesses for the date and time Resident #286's credit card was used. He stated he brought a photo from the footage back to the facility and the Human Resources Director identified the suspect as NA #8. He went on to say based on this evidence, an arrest warrant had been issued for NA #8 for the incidents.

On 12/19/23 at 10:37 AM a telephone interview with Social Worker (SW) #2 indicated she recalled participating in an investigation regarding misappropriation of resident property. She stated she recalled this being for Resident #286. She went on to say she had interviewed alert and oriented residents on whether they had observed anything suspicious. SW #2 stated she could not recall which residents she interviewed, and she did not document these interviews anywhere. She stated she did not recall interviewing families of any cognitively impaired residents.

On 12/20/23 at 10:55 AM in an interview the Human Resources Director confirmed she was able to identify NA #8 when Investigator #1 showed her the picture of the suspect. She stated NA #8's preemployment criminal background

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check and Nurse Aide Registry check were things that should have been done and then placed in NA #8's employment folder. She went on to say she had gone into the computer system and tried to pull them up again but had been unable to locate them.

2. Resident #12 was admitted to the facility on 3/16/23 with a diagnosis of cerebrovascular disease.

A review of Resident #12's admission Minimum Data Set (MDS) assessment dated 3/23/23 revealed she was cognitively intact.

A review of the facility's initial allegation report dated 6/19/23 revealed in part on 6/19/23 Resident #12's family member reported to the facility that a fraudulent charge on 4/21/23 had shown up on Resident #12's credit card statement. Resident #12's family member had gone through Resident #12's personal belongings and discovered her credit card was missing. The Greenville North Carolina (NC) police were notified.

A review of the Greenville NC police report dated 9/27/23 written by Greenville NC Police Investigator #1 revealed in part Resident #12 had been under the care of NA #8 at the facility. On 4/21/23 a charge of $350.46 was made at a business with Resident #12's credit card. Investigator #1 investigated a similar case at the same facility during the same time frame where NA #8 was charged with 1 count of financial card theft and 7 counts of obtaining property under false pretenses for those incidents. What was significant was that Resident #12's credit card

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was used at one of the same businesses involved in the previous case. Investigator #1 was waiting to see if he could obtain video footage from the business. A supplemental entry to this police report dated 11/27/23 revealed Investigator #1 had not been able to obtain video footage for the incident from the business. Due to circumstances surrounding the case, probable cause existed, and a warrant was secured for the arrest of NA #8 for 1 count of financial card theft and 1 count of obtaining property under false pretenses in Resident #12's case.

On 12/19/23 a review of NA #8's employee file revealed her hire date was 2/28/22. There was no evidence of a preemployment criminal background check or preemployment Nurse Aide Registry check.

On 12/19/23 at 9:50 AM an interview with the Administrator indicated she initiated the facility investigation of this incident on 6/19/23. She stated staff who were working on the same assignment at the time the credit card charge occurred were interviewed to determine if they had seen or heard anything suspicious and written statements were obtained. She stated she did not recall which staff were interviewed. She went on to say she did not know what happened to the written statements as they were not in the investigation folder. The Administrator stated she thought they must have been taken by the police investigator. She stated Social Worker #2 had interviewed alert and oriented residents who resided on the same hall as Resident #12 at the time of the incident. She further indicated she did not know why there was no documentation of these resident interviews in the facility's investigation of the incident. The Administrator

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stated family members of cognitively impaired residents had not been interviewed regarding any missing property or unrecognized credit card charges. At 3:00 PM a follow-up interview with the Administrator indicated she did not know why there was no record of NA #8's preemployment criminal background check or preemployment Nurse Aide Registry check in the facility investigation. She stated the facility required these when NA #8 was hired. She went on to say she knew they had been done because she had seen them. She further indicated NA #8 had nothing on her preemployment criminal background check and no findings against her on her preemployment Nurse Aide Registry check, but she did not know where the documents had gone. She stated after this allegation, she provided an update to the Health Care Personnel Registry regarding NA #8, asked if she needed to do a new investigation, and was told she did not.

On 12/19/23 at 10:37 AM a telephone interview with Social Worker (SW) #2 indicated she recalled participating in an investigation regarding misappropriation of resident property. She stated she recalled this being for Resident #286. She went on to say she had interviewed alert and oriented residents on whether they had observed anything suspicious. SW #2 stated she could not recall which residents she interviewed, and she did not document these interviews anywhere. She stated she did not recall interviewing families of any cognitively impaired residents. She went on to say she did not recall doing this again for Resident #12.

On 12/19/23 at 1:04 PM a telephone interview with Investigator #1 indicated he investigated another case involving a resident of the same

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F 607	Continued From page 22 facility previously. He stated in that case he viewed video surveillance footage at multiple businesses for the date and time the resident's credit card was used. He stated he brought a photo from the footage back to the facility and the Human Resources Director identified the suspect as NA #8. He went on to say based on this evidence, an arrest warrant for NA #8 for those incidents. He further indicated although he was not able to view video footage for the case involving Resident #12, because Resident #12's credit card was used at one of the same businesses, he had probable cause to obtain an arrest warrant for NA #8 in Resident #12's case as well. On 12/20/23 at 10:55 AM in an interview the Human Resources Director confirmed she was able to identify NA #8 when Investigator #1 showed her the picture of the suspect. She stated NA #8's preemployment criminal background check and Nurse Aide Registry check were things that should have been done and then placed in NA #8's employment folder. She went on to say she had gone into the computer system and tried to pull them up again but had been unable to locate them.	F 607		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		1/24/24

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F 657	Continued From page 23 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to have care plan meetings for 1 of 2 residents reviewed for care plan meetings (Resident #2). Findings included: Resident #2 was admitted to the facility on 3/02/20 with diagnoses which included chronic obstructive pulmonary disease and neurogenic bladder. The annual Minimum Data Set dated 10/19/23 indicated that Resident #2 was cognitively intact. An interview on 12/17/23 at 2:33 PM with Resident #2 revealed they had not been invited to a care plan meeting since February 15, 2023.	F 657	F-657 – Care Plan Timing 1. Immediate action(s) taken for the resident(s) found to have been affected include. • Education was conducted with all three Social Workers by the Administrator on proper process and timeline for completion of Resident Care Plans. 2. Actions taken/systems put into place to reduce the risk of future occurrence include: • The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place	

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F 657	Continued From page 24 An interview on 12/19/23 at 9:00 AM with the Social Worker (SW) #1 revealed that Resident #2 had not had a care plan meeting since 2/15/23. She stated she was aware of the requirement to have a care plan meeting quarterly but had not done so for Resident #2. She stated that it was not a priority for her and it had not been done. An interview on 12/20/23 at 8:30 AM with the Administrator revealed she was unaware that Resident #2 had not had a care plan meeting quarterly as required and did not know why.	F 657	to reduce the risk of future occurrence include: • Education was completed on 1/19/24 with all three Social Workers by the Administrator on proper process and timeline for completion of Resident Care Plans. Any new hires in the Social Work department will be educated upon hire by the Social Services Director or Administrator. • • The Director of Social Services completed an audit of all resident care plans to ensure all residents had a completed quarterly and annual care plan within the correct timeframe. No additional concerns were noted. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: • The Director of Social Services will create a Care Plan calendar detailing when each current resident is due for a quarterly or annual care plan. New admits will be added to the calendar as appropriate. This calendar will be shared with all social workers and other appropriate parties. • The Director of Social Services will audit Resident Care Plans 5 times a week for 4 weeks, bi-weekly for 2 weeks and monthly for 2 months to ensure care plans were conducted in a timely manner according to the Care Plan calendar. The Social Services Director will bring audits to QAPI monthly. • Any deficient practice found during the audits will be corrected immediately	

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F 657	Continued From page 25	F 657	and education and/or corrective action done as appropriate. • The Audit findings will be reported in a Monthly QAPI meeting for a minimum of 3 months. Corrective action completion date: 1/24/24	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, and resident interviews the facility failed to complete an accurate assessment for 1 of 1 resident reviewed. Resident #118 experienced bleeding following the debridement of her right great toenail. Findings included: Resident # 118 was admitted to the facility on 5/5/23 with a diagnosis that included type 2 diabetes with neuropathy, and chronic kidney disease (CKD) stage 3.	F 684	F-684 – Quality of Care 1. Immediate action(s) taken for the resident(s) found to have been affected include: DON immediately went to the room with facility Nurse Practitioner to assess resident. Nurse Practitioner completed a wound culture to be processed. Resident visited outside podiatry appointment the following week for follow-up. 2. Identification of other residents having the potential to be affected was	1/24/24

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F 684	Continued From page 26 Review of the quarterly Minimum Data Set (MDS) dated 10/2/23 revealed resident #118 was cognitively intact. Review of care plan dated 5/5/23 and revised 10/16/23 revealed a problem that Resident #118 was at risk for altered non pressure related skin integrity related to fragile skin. With Interventions that included staff would manage factors that increased risks for altered skin integrity, skin would be observed during activities of daily living care for any changes in skin condition and the nurse would be notified, and weekly skin assessments would be done by the treatment nurse. Review of podiatry visit summary and progress notes dated 12/6/23 revealed that Resident #118 had a podiatric diagnosis of atherosclerosis (a thickening or hardening of the arteries) of the extremities, onychomycosis (fungal infection of the nail unit); type 2 diabetes mellitus with peripheral circulation disorders. Resident #118 was evaluated, examined, and treated at bedside. The note further the toenails were debrided without incident. No signs of infection were noted. The nails were debrided by manual method. On 12/17/23 at 1:57 PM an interview with Resident #118 revealed she was concerned about a wound on her right great toe from where the Podiatrist cut her toenails recently. She stated she was diabetic and was concerned it would get infected. Resident #118 stated that she did not notice the wound right away because she had no feeling in her feet, so it did not hurt. Resident #118 stated it was a family member that first noticed blood on her sock over the right great toe when she visited the following day (12/7/23) and	F 684	accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Director of Nursing educated licensed nursing staff on reporting change of conditions to Physican and completing proper notifications to resident representatives and other necessary staff. Education will be completed for current staff by 1/24/24. All newly hired licensed nursing staff will be educated on reporting changes of condition by the Staff Development Coordinator or ADON. Facility treatment nurse, Director of Nursing and Assistant Director of Nursing completed skin audits on all residents seen by Podiatry in the last 3 months. No additional concerns were noted. The facility will complete education with licensed nursing staff on accurate nursing assessments and what to do with the finding as well as notifications to family and MD and get a treatment in place if necessary. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: DON/ADON to audit 5 assessments/SBARS per week for accuracy and to ensure that the proper notifications were done for negative findings as well as verify that orders were	

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F 684	Continued From page 27 notified staff and they cleaned it and put an adhesive bandage on her toe. She did not recall the name of the staff that was notified but, since the injury, staff sometimes cleaned the wound and left it open to air and that her family members also cleaned it when they visited. In a phone interview with Nurse #2 on 12/19/23 at 8:43 AM it was revealed that Nurse #2 was familiar with and assigned to Resident #118 when on duty. Nurse #2 indicated that she did the skin assessments for Resident #118 on Tuesdays on day shift when Resident #118 got her bath. Nurse #2 indicated that she did the previous 3 skin assessments dated 11/21/23, 12/5/23, and 12/12/23 on Resident #118. She further indicated that the podiatry clinic was held on Tuesday 12/5/23 or Wednesday 12/6/23 and she next saw the resident on Thursday 12/7/23 or Friday 12/8/23. She further indicated that when she saw Resident #118 that there was an adhesive bandage on her right great toe that had residual dried blood on it, so she cleaned it and left it open to air, so it would not get infected. She stated there was also dried blood noted on the right great toe of Resident #118 and you could see the indentation of where the cut toenail had previously been, but the tissue looked healthy. She stated the blood on the adhesive bandage was old blood and she only cleaned the wound because the resident said she wanted it cleaned. Nurse #2 indicated that a family member of Resident #118 was concerned about her toe when she visited on 12/7/23 or 12/8/23. She further indicated that she and the family member went to the room of Resident #118, removed the adhesive bandage and looked at the toe together. She indicated to the family member that the wound was clean and without swelling or odor,	F 684	put into place if necessary. We will do this 5 days a week x 4 weeks and then biweekly x 2 weeks and then weekly x 1 weekly and monthly in QAPI x 3 months. Director of Nursing will bring results of audits to QAPI monthly. Corrective action completion date: 1/24/24.	

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F 684	Continued From page 28 but the nail was noticed to be cut too short. Nurse #2 stated that she did not notify the physician or the podiatrist. Record review of skin assessment dated 12/12/23 completed by Nurse #2 revealed no new skin changes.	F 684		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to prevent the potential for cross-contamination by storing plastic scoops inside dry ingredient bins allowing the handles to touch the dry ingredients for 2 of 2 observations. Findings included:	F 812	F-812 – Food Procurement 1. Immediate action(s) taken for the resident(s) found to have been affected include: Both flour and sugar bins were immediately removed from use, emptied	1/24/24

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F 812	Continued From page 29 During an observation of the kitchen on 12/17/23 at 10:35 AM the flour and sugar scoops were observed in the flour and sugar bins and the handles were visibly touching the flower and sugar. During observation of the kitchen on 12/18/23 at 12:43 PM the flour and sugar scoops were again observed in the flour and sugar bins and the handles were visibly touching the flower and sugar. During an interview on 12/18/23 at 12:46 PM the Kitchen Supervisor stated scoops were not to be stored inside the storage bin due to sanitation concerns with the handle. The scoops would normally be put on a container on top of the storage bin. He concluded he was unsure why they were all stored in the storage bins, and they should not have been stored in that way. During an interview on 12/18/23 at 10:55 AM the Dietary Manager stated the scoops for the flour and sugar bins were to be stored outside of the flour and sugar bins to prevent contamination of the product by the scoop handle.	F 812	of all contents and cleaned before ingredients were replenished. All dietary employees were educated that all ingredient scoops are to be stored outside of ingredient bins to prevent cross contamination. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Dietary Manager will in-service the dietary staff on proper storage, labeling and dating of food items and food utensils in the dietary department. The Dietary Manager will be responsible for in servicing all new dietary employees during their orientation on proper storage, labeling and dating of food items and food utensils. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Dietary Manager will create an inspection checklist that Dietary Supervisors will perform Monday through Sunday. The Dietary Supervisors will note on the checklist if scoops were appropriately stored outside of their containers. If not, they will correct the problem and issue corrective action to those responsible.	

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F 812	Continued From page 30	F 812	This process will be monitored daily for 4 weeks, weekly for 2 weeks and monthly for 3 months. The Dietary Manager will bring the results of these audits to QAPI monthly. Compliance Date: 1/24/24	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		1/24/24

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§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 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

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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 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:

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F 867	Continued From page 33 (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 observation and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This was for one repeat deficiency in the area of Food Procurement, Store/Prepare/Serve-Sanitary (F812) originally cited on 5/14/21 during a recertification and complaint investigation survey and subsequently cited on 12/22/23 during the recertification and complaint investigation survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. This tag is cross referenced to: F812: Based on observations and staff interviews the facility failed to prevent the potential for cross-contamination by storing plastic scoops inside dry ingredient bins allowing the handles to touch the dry ingredients for 2 of 2 observations. During the recertification and complaint investigation survey of 5/14/21 the facility was cited for failing to keep food on the tray line at a safe temperature, to discard expired foods, and to label food from outside of the food. In an interview with the Administrator on 12/22/23	F 867	F-867 QAPI/QAA 1. Immediate action(s) taken for the resident(s) found to have been affected include: Both flour and sugar bins were immediately removed from use, emptied of all contents and cleaned before ingredients were replenished. All dietary employees were educated that all ingredient scoops are to be stored outside of ingredient bins to prevent cross contamination. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Dietary Manager will in-service the dietary staff on proper storage, labeling and dating of food items and food utensils in the dietary department. The Dietary Manager will be responsible for in servicing all new dietary employees during their orientation on proper storage,	

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F 867	Continued From page 34 at 1:45 PM she stated she was not employed by the facility during the 2021 survey and she was unsure of what the performance improvement plan was for that deficiency. She further stated that there was a lot of staff turnover in the kitchen which may have contributed to the repeat concern.	F 867	labeling and dating of food items and food utensils. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Dietary Manager will create an inspection checklist that Dietary Supervisors will perform Monday through Sunday. The Dietary Supervisors will note on the checklist if scoops were appropriately stored outside of their containers. If not, they will correct the problem and issue corrective action to those responsible. This process will be monitored daily for 4 weeks, weekly for 2 weeks and monthly for 3 months. The Dietary Manager will bring the results of these audits to QAPI monthly. Compliance Date: 1/24/24	
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		1/24/24

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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

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	345168	A. BUILDING _____ B. WING _____	C 12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACGREGOR DOWNS HEALTH CENTER BY HARBORVIEW	2910 MACGREGOR DOWNS ROAD GREENVILLE, NC 27834

(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 883	Continued From page 36 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, Responsible Party and the Vaccine Distribution and Help Desk Supervisor at the North Carolina Immunization Registry interviews the facility failed to provide education regarding the benefits and possible side effects of a pneumococcal vaccine, offer a pneumococcal vaccine, and then document either a refusal or the administration of a pneumococcal vaccine for 1 of 5 residents (Resident #19) reviewed for immunizations. Findings included: A review of the facility policy titled "Vaccination of Residents" last revised October 2019 read in part, "All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated. All new residents shall be assessed for current vaccination status on admission. Certain vaccines (e.g., influenza and pneumococcal vaccines) may be administered per the physician-approved facility protocol (standing orders) after the resident has been assessed by the physician for medical contraindications for each vaccine." A review of the CDC (Centers for Disease Control and Prevention) document titled, "Pneumococcal Vaccination: Summary of who and when to vaccinate" dated last reviewed on 9/22/23 indicated in part for adults aged 65 years and older who had never received any pneumococcal vaccine one dose of either a 15 valent pneumococcal conjugate vaccine (PCV) or one	F 883	F-883 □ Influenza and Pneumococcal Immunizations 1. Immediate action(s) taken for the resident(s) found to have been affected include: DON immediately re-educated Admissions Nurse on requirement to offer and education all residents on both the Influenza and Pneumococcal vaccines upon admission 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: " An audit was completed for all current residents to ensure documentation is in place that the resident was educated and offered the Influenza and Pneumococcal vaccine. If resident refuses, documentation must be completed in resident□s medical record to reflect their refusal. No additional concerns were found during this audit. " Current Admissions Nurse was re-educated by Director of Nursing on proper process for offering vaccinations. All future Admission Nurses will receive	

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F 883	Continued From page 37 dose of a 20 valent PCV vaccine should be administered. Resident #19 was admitted to the facility on 12/17/21 with a diagnosis of diabetes. A review of her quarterly Minimum Data Set (MDS) assessment dated 9/21/23 revealed in part she was 67 years old. She was cognitively intact. Her pneumococcal vaccination was not up to date. A pneumococcal vaccine had not been offered. On 12/19/23 a review of the immunizations tab in Resident #19's electronic medical record revealed no historical data regarding the administration of a pneumococcal vaccine. On 12/20/23 at 8:15 AM the facility Corporate Nurse Consultant provided a document titled "North Carolina Immunization Registry Client Schedule" for Resident #19. The document revealed a vaccine "History" section. The vaccine "History" section did not include documentation of any pneumococcal vaccine. At 9:18 AM during a review of the document with the Corporate Nurse Consultant she indicated the document titled "North Carolina Immunization Registry Client Schedule" printed from the North Carolina Immunization Registry website was the record Resident #19 received a pneumococcal vaccine. On 12/20/23 at 9:02 AM a telephone interview with the Vaccine Distribution and Help Desk Supervisor at the North Carolina Immunization Registry indicated she was currently viewing the "North Carolina Immunization Registry Client Schedule" document for Resident #19. She stated the list of "Vaccines Recommended by	F 883	education upon hire by Staff Development Coordinator or Director of Nursing 4. How the corrective action(s) will be monitored to ensure the practice will not recur: " All new admissions will be audited by the DON/ADON to ensure education was provided for both Influenza and Pneumococcal vaccine, if the vaccine was given and if the vaccine was refused. " These audits will be completed 5 days a week for 4 weeks, bi weekly for 2 weeks and weekly for 2 months. The results of these audits will be brought by the DON to QAPI monthly. Corrective action completion date: 1/24/24	

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F 883	Continued From page 38	F 883		

Selected Tracking Schedule" section was a list of vaccines recommended for Resident #19. She stated there was not a record of the vaccine administration for the pneumococcal vaccine. She went on to say the North Carolina Immunization Registry had no record of a history of pneumococcal vaccine for Resident #19. She further indicated the North Carolina Immunization Registry was initiated in 2005 for pediatric patients. She stated most older adults would not have an immunization history with the Registry unless a provider uploaded them.

On 12/20/23 at 8:28 AM an interview with Resident #19 indicated she thought she had received a pneumococcal vaccine at the facility a couple of months ago. She stated if she were due for a pneumococcal vaccine, she would want to receive one.

On 12/20/23 at 8:32 AM a telephone interview with Resident #19's Responsible Party (RP) indicated she was not aware of Resident #19 ever having received a pneumococcal vaccine. She stated if Resident #19 was due for a pneumococcal vaccine, she would want her to have one.

On 12/20/23 at 9:21 AM an interview with the Director of Nursing (DON) indicated there was no documentation Resident #19 ever received a pneumococcal vaccine. She went on to say the facility's Staff Development Coordinator (SDC) was responsible for tracking and making sure resident's vaccines were up to date. She stated there had been a lot of turnover in the SDC position. The DON stated she had been trying to fill in but had been concentrating on making sure residents were up to date with the influenza

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F 883	Continued From page 39 vaccine. She went on to say the next focus would be pneumococcal vaccines. On 12/20/23 at 10:39 AM an interview with the Corporate Nurse Consultant indicated there had been staffing changes at the facility with regards to who was tracking resident's immunizations and the ball had gotten dropped. She stated the facility would now focus on which residents needed what vaccines and would fix it.	F 883		