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THE CITADEL MOORESVILLE	**550 GLENWOOD DRIVE MOORESVILLE, NC 28115**

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E 000	Initial Comments An unannounced recertification survey and complaint investigation survey was conducted on 01/22/24 through 02/01/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: X8V811.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint survey was conducted on 01/22/24 through 01/26/24. The survey team returned to facility on 02/01/24 to complete the extended survey. Therefore, the exit date was changed to 02/01/24. The following intakes were investigated NC00198131, NC00199918, NC00201316, NC00202200, NC00202386, NC00204007, NC00204359, NC00205662, NC00206560, NC00207432, NC00208098, NC00209485, NC00210845. 15 of the 31 complaint allegation resulted in deficiencies. Immedicate Jeopardy was identified at: CFR 483.12 tag F602 scope and severity of J. CFR 483.12 tag F607 scope and severity of K. The tags F602 and F607 constituted Substandard Quality of Care. Immediate jeopardy began on 02/23/23 and was removed on 01/30/24. An extended survey was conducted. This survey was posted one day late on 02/16/24 due to management review and revisions.	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.	F 550		3/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/26/2024

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

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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.

§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.

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F 550	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record reviews, and resident and staff interviews, the facility failed to treat residents in a dignified manner when staff spoke to a resident in a disrespectful manner. The resident expressed feelings of anger, upset, and disrespect. This affected 1 of 3 residents reviewed for dignity and respect (Resident #74). The findings included: Resident #74 was admitted to the facility on 09/15/22. Review of Resident #74's annual Minimum Data Set (MDS) dated 09/23/23 revealed Resident #74's cognition was intact was independent for bathing. An interview conducted with Resident #74 on 01/26/24 at 10:20 AM revealed early one morning of October 2023 the resident was in the shower room taking a shower when Nurse Aide (NA) #6 came into the shower room. Resident #74 further revealed NA #6 yelled at him and stated that he should not be in the shower room and refused to give her name. Resident #74 stated he had to tell the NA to leave the shower room for privacy. Resident #74 left the shower room once he dried off and went directly to the Nurse #17 on the hall to get the NA's name and to tell the Nurse about the incident. Resident #74 indicated he spoke to the Nurse and the Business Office Manager (BOM) regarding the incident, but no one ever resolved the situation. Resident #74 indicated NA #6 comes into his room to gather laundry and trash bags sometimes. Resident #74 revealed he felt angry, upset, and disrespected that the NA	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 RESIDENT RIGHTS On February 20, 2024, the Director of Nursing educated NA #6 on treating residents in a dignified manner. On January 29, 2024, Social Worker met with Resident #74 regarding the incident and Resident #74 no longer wanted to discuss it. On February 20, 2024, Social Worker began interviewing Residents to determine if any Residents were upset, had feelings of anger, or being disrespected regarding the treatment from the staff. Two Residents were identified, and coaching was done with the identified staff member on February 22, 2024. On February 20, 2024, the Director of Nursing/Staff Development Coordinator/Social Worker began in-servicing all staff, to include agency/contracted staff, on Resident Rights and treating residents in a dignified manner. The Director of Nursing/SDC/SW will ensure all current staff, who have not	

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yelled at him, and that the facility continued to let the NA have communication with the resident.

An interview conducted with Nurse #17 on 01/26/24 at 10:30 AM revealed Resident #74 came to her visibly upset in October that NA #17 had been rude to the resident. Nurse #1 indicated she did not witness the conversation but could hear NA #17 being loud at the Resident. Nurse #17 further revealed Resident #74 indicated he was taking a shower and NA #17 yelled at him and he could not be in the shower room and had to leave. Nurse #17 revealed Resident #74 was independent for bathing and was allowed to shower at his convenience. Nurse #17 indicated she gave Resident #74 the NA #6's name and reported the incident to the Administrator.

An interview conducted with the BOM on 01/26/24 at 12:35 PM revealed she had a conversation with Resident #74 in October and the resident revealed NA #6 had yelled at him for being in the shower room. The BM further revealed she reported it to the prior Director of Nursing but does not recall what happened after that.

A phone interview was conducted with NA #6 on 01/26/24 at 12:50 PM revealed in October she had entered the shower room and Resident #74 was giving himself a shower. NA #6 further revealed she asked Resident #74 why he was in the shower because it was not his scheduled shower day and asked how long it would be. The NA indicated resident #74 was upset and told her to leave the shower room. NA #6 stated she did not rush Resident #74 and did not speak to him in a disrespectful manner. The NA revealed she reported the incident to Unit Manager #2 (UM),

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received this education by March 5, 2024, will not be allowed to work until education is completed. The Director of Nursing/SDC/SW will ensure newly hired staff, to include agency/contracted staff, will receive education during facility orientation in-person or via telephone prior to working.
The Director of Nursing/SDC/SW will monitor using a Quality Assurance tool for Resident Rights. The monitoring will include a sample of resident interviews regarding treatment in a dignified manner. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/SDC/SW will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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F 550	Continued From page 4 and nobody had talked to her about the incident. An interview conducted with the Unit Manager #2 (UM) on 01/26/23 at 2:35 PM revealed she did not recall any incident with Resident #74. UM #2 further revealed NA #1 had never reported any incident with Resident #74. An interview conducted with the Administrator on 01/26/24 at 3:50 PM revealed she was not aware of the incident until today. The Administrator revealed Resident #74 was independent and was able to shower in the shower room at any time that was appropriate. The Administrator indicated she expected staff to always wear a badge and to treat all residents with dignity and respect.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to assess a resident's ability to self-administer medications for 2 of 2 residents reviewed for medications at bedside (Resident #87 and Resident #33). The findings included: 1. Resident #87 was admitted to the facility on 10/18/23 with diagnoses that included chronic obstructive pulmonary disease, dementia, atrial fibrillation, fracture of T11-T12, and protein calorie malnutrition.	F 554	On January 23, 2024, Nurse #6 removed Resident #87 medications from the room. On January 24, 2024, the Director of Nursing spoke with the Physician Assistant regarding Resident #87's ability to self-administer medication and it was determined clinically inappropriate. A review of the medications at the bedside were reviewed for physician's orders and no new orders were initiated. On January 23, 2024, Nurse #10 removed Resident #33 medication from her room. Resident #33 had a current prn order for	3/5/24

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Review of the quarterly Minimum Data Set (MDS) assessment dated 11/10/23 revealed that Resident #87 was cognitively intact and had no delirium or behaviors but rejected care 1 to 3 days during the observation period.

Review of Resident #87's medical record revealed no documentation that Resident #87 had been assessed to self-administer medications at bedside.

Further review of Resident #87's medical record revealed no care plan for self-administration of medications.

An observation and interview were conducted with Resident #87 on 01/22/24 at 12:37 PM. Resident #87 was resting in bed and had just gotten back from the shower. She was noted to have a basket of over-the-counter medications sitting on top of the air conditioning unit. The basket contained Taurine (vitamin that has effect of fat metabolism) 1000 milligrams (mg), Zinc Carnosine, Phillips Stool Softener, P5P dietary supplement (vitamin b replacement), Nac Glycine powder (helps break down mucus in the body), and Saline Spray. Resident #87 stated that she took "some of them from time to time" but the staff brought her most of her medication. Resident #87 was concerned that the over-the-counter medication would draw moisture from sitting on the top of the air conditioning unit and stated she needed to find another place to set them.

An observation of Resident #87's room was conducted on 01/23/24 at 9:35 AM. The basket of over the medication remained sitting on top of the

F 554

the medication and was educated to ask for it as needed. On January 24, 2024, the Director of Nursing spoke with the Physician Assistant regarding Resident #33 ability to self-administer medication and it was determined clinical inappropriate due to the assessment needed prior to administration.
On January 24, 2024, the Director of Nursing/Staff Development Coordinator/Unit Manager began auditing residents' rooms to determine if medications were identified at bedside, orders in place to self-administer, and care planned. Two residents (A.H. and TH) were identified with biofreeze at their bedside. Residents didn't want to keep it in their rooms, so UM #1 removed them.
On January 23, 2024, the Director of Nursing/Staff Development Coordinator/Unit Manager began in-servicing all staff, to include agency/contracted staff, on identifying medications at residents beside and notifying the licensed nurses. Licensed nurses will be educated regarding self-administration assessment, physician orders and care planning. On January 27, 2024, the Administrator mailed letters to the Residents responsible party communicating the need to make the facility aware when ordering medications and having them shipped to the facility. Working in collaboration ensures processes are implemented for our resident's safety. The Director of Nursing/Staff Development Coordinator/Unit Managers will ensure all current staff, who have not received this

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air conditioning unit in Resident #87's room.

Review of Resident #87's physician orders sheet dated January 2023 revealed no physician orders for the Taurine, Zinc Carnosine, Phillips Stool Softener, P5P supplement, Nac Glycine powder, and Saline Spray.

Nurse #6 was interviewed on 01/23/24 at 3:48 PM and stated the staff gave all of the residents their medication and was not aware of any residents that self-administers medication. Nurse #6 stated that residents were never allowed to keep medications at bedside, if the resident wanted to self-administer medication they would have to be evaluated and the physician notified to ensure that it could be done safely. Nurse #6 was asked to observe Resident #87's room and the basket of over-the-counter medication. Nurse #6 stated she would go and talk to Resident #87 and if Resident #87 wanted to take those medications, she would get an order for them.

Nurse #2 was interviewed on 01/23/24 at 3:50 PM and stated she was serving as the charge nurse. She was not aware of any resident that self-administered medications. Nurse #2 further stated if a resident wanted to self-administer medications, she would discuss it with the Director of Nursing (DON) and physician and obtain an order to do so.

The DON was interviewed on 01/26/24 at 1:03 PM and stated that she had been at the facility for three weeks. She stated that as far she knew they had no one that kept medications at bedside and/or self-administered medications. "I would expect the staff to follow our policy for self-administration of medication and make sure

F 554

education by March 5, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure newly hired staff, to include agency/contracted staff, will receive education during facility orientation in-person or via telephone prior to working.
The Director of Nursing/Staff Develop Coordinator/Unit Manager will monitor using a Quality Assurance tool for Resident Self Administration. The monitoring will include a sample of resident room observations for medications at bedside, self-assessment, physician orders, and care planned. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Staff Development Coordinator/Unit Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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that it was appropriate after they were assessed". She added that they had started education on keeping medications at bedside earlier in the week, when another resident was noted to have medications at bedside.

2. Resident #33 was admitted to the facility on 05/07/20.

A review of Resident #33's physician orders revealed an order dated 08/15/23 for an Antidiarrheal Suspension 262 milligrams (MG) per 15 milliliters (ML) give 30 ml by mouth every 4 hours as needed for stomach pain or diarrhea.

Review of Resident #33's electronic medical record (EMR) revealed no physician orders were received for the Resident to self-administer any medications. Further review of the EMR revealed there was no documentation of a medication self-administration assessment having been completed for the Resident.

Review of Resident #33's current care plan (revised 10/10/23) revealed the Resident was not care planned for self-administration of medications.

Review of Resident #33's quarterly Minimum Data Set assessment dated 11/03/23 indicated she was cognitively intact.

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On 01/22/24 at 11:11 AM an observation and interview were made with Resident #33. An observation was made of a bottle of the antidiarrheal agent approximately ¾ full sitting on the Resident's bedside table. There was no prescription with the Resident's name or the directions of use on the bottle. Resident #33 explained that she had to keep it in her room to take for her hiatal hernia.

During an observation on 01/23/24 at 10:40 AM the antidiarrheal medication was still sitting on Resident #33's bedside table.

On 01/23/24 at 3:26 PM an interview was conducted with Medication Aide (MA) #2 who occasionally medicated Resident #33. The MA explained that for a resident to have medication in their room they would have to have an order to be able to self-medicate and as far as she knew she did not have a resident that was allowed to self-medicate.

An observation was made on 01/23/24 at 3:30 PM of the antidiarrheal agent still sitting on Resident #33's bedside table.

An interview was conducted with Nurse #10 on 01/23/24 at 3:33 PM. The Nurse explained that she often medicated Resident #33 and that the Resident did not have an order to self-medicate. Accompanied Nurse #10 to Resident #33's room to find the antidiarrheal agent on her bedside table. The Resident informed the Nurse that she needed to have the medication because she "had a hiatal hernia and I need to drink it a lot".

During an interview with the Unit Manager (UM) #1 on 01/23/24 at 3:42 PM the UM explained the

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F 554	Continued From page 9 residents had to be able to tell you what the medication is and how to take it before they can self-medicate. She indicated she did not know of any resident that had an order to self-medicate. The UM stated the staff were taught to look for things like medications that were at the residents' bedside when they made their rounds. An interview conducted with the Administrator on 01/24/24 at 10:44 AM revealed Resident #10 should have been assessed to be mentally and physically able to self-medicate as well as having a care plan to be able to do so. The Administrator indicated they needed to do a better job of training the staff to look for medications at the residents' bedside.	F 554		
F 602 SS=J	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, news article review, North Carolina Board of Nursing Investigator, staff, power of attorney, and detective interviews the facility failed to assure that a resident's (Resident #156) property was safeguarded, and that staff did not misappropriate the resident's property. Nurse #1 was found to have in her possession Resident #156's driver's license, social security card, and debit card without his	F 602	F602 Resident #156 expired 12-13-2023. On January 26, 2024, the Unit Managers and Social Workers began interviewing current Residents who are their own responsible party to determine interest in	3/4/24

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permission or knowledge and was alleged to have made unauthorized charges on the debit card which included reoccurring charges to a taxi services, online shopping services, and a gas station in a nearby county (Gastonia). The unauthorized charges started in February 2023 and recurred until the card was cancelled in April 2023 for an undisclosed amount of money. The reasonable person concept was applied for this deficient practice in that a reasonable person would have the high likelihood of being upset about the loss of financial resources, the invasion into one's personal financial status, and increased anxiety over the risk of identity theft. The deficient practice was discovered for 1 of 3 residents reviewed for abuse, neglect, and misappropriation of resident property.

Immediate Jeopardy began on 2/23/23 when Nurse #1 first worked in the facility and likely misappropriated Resident #156's documents, including his driver's license, social security card, and bank debit card. Immediate jeopardy was removed on 01/30/24 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity of D (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education.

The findings included:

Resident #156 was admitted to the facility on 03/17/20 with diagnoses that included Parkinson's disease (chronic degenerative disorder), heart disease, and congestive heart failure. Resident #156 expired on 12/13/23.

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a locked box and/or Resident trust fund account to safeguard their belongings. As of February 19, 2024, twenty-eight Residents have nightstands with keys or wall lock boxes with keys.

On January 26, 2024, the Administrator and the Director of Nursing were educated by the Chief Nursing Officer and Regional Director of Operations on misappropriation of resident property to include facility options to secure resident possessions such as locked boxes and resident trust accounts.
On January 26, 2024, the Administrator/Staff Development Coordinator/Unit Manager/Social Worker began educating all staff on options of lock boxes and resident trust accounts to secure belongings. The Administrator mailed letters on January 27, 2024, to Resident’s responsible parties that included education related to resident lock boxes and resident trust accounts to aid in safeguarding resident possessions.
The Administrator/Staff Development Coordinator/Social Worker will be responsible for ensuring all staff, to include agency/contract staff, receive the Abuse and Neglect education to include misappropriation of resident funds that include facility options to secure resident possessions. The Director of Nursing/Staff Development Coordinator will ensure all current staff who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of

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Review of Resident #156's medical record revealed no record of inventory of his personal belongings that he had in his possession upon admission to the facility, or during any part of his stay. Further review of Resident #156's history of stay revealed that he had been hospitalized on 01/02/22 and readmitted to the facility on 01/04/22 and remained in the facility until 04/12/23. He was again hospitalized on 04/12/23 and readmitted on 04/17/23 and remained in the facility until his passing on 12/13/23.

A quarterly Minimum Data Set (MDS) dated 04/20/23 revealed Resident #156 was cognitively intact and had no behaviors.

A facility document titled "Timecard Detail Report" for 02/19/23-03/04/23 indicated that Nurse #1 an agency nurse clocked into the facility on 02/23/23 at 7:30 PM and clocked out at 7:07 AM and on 02/24/23 she had clocked in at 11:07 PM and clocked out at 7:07 AM.

Review of the Iredell Free News website article titled "[County Sherriff's Office] ICSO Felony Arrests Mary 12-18 [2023]" revealed Nurse #1, on May 16, 2023, was "charged with seven counts of taking a financial transaction card, possession of methamphetamine, maintaining a dwelling or vehicle for sale or use of controlled substances and a misdemeanor drug offense."

An email dated 05/18/23 from Detective #1 to the Administrator read, as discussed, the detective was emailing about the incident with Resident #156 and the theft of his North Carolina Driver's License, his social security card, and his bank debit card. The detective spoke with Resident

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Nursing/Staff Development Coordinator will ensure newly hired staff, to include agency/contracted staff, will receive education during facility orientation in-person or via telephone prior to working.
The Administrator/Staff Development Coordinator/Social Worker will monitor using a Quality Assurance tool for securing Resident belongings. The monitoring will include a sample of five (5) Residents to ensure their belongings are safeguarded. The QA monitoring will be conducted weekly x 12 weeks. The Director of Nursing/Staff Development Coordinator/Unit/Social Worker will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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#156 via phone, and the resident advised he did not report the documents stolen because with his declining health and issue with memory he thought maybe he just lost it or hid it and could not remember where he put it. Resident #156 further stated he closed the debit card once he realized it was gone and did not worry about the license or social security card because he was in the nursing home, and he did not need it at the time. The detective explained when Nurse #1 was stopped by a police officer, she was found to have both the driver's license and social security card for Resident #156 in her possession along with multiple other bank cards for other elderly people. Nurse #1 was charged for other cards which were in her possession. During the investigation it was discovered all of the alleged victims had been in and out of hospitals, have had to have home health care, and the detective had been attempting to identify how all of the patients (alleged victims) may have been linked (to Nurse #1) and that was how she found Resident #156 and the facility. Resident #156's license and card were in the evidence locker at the county sheriff's office and would be held until after Nurse #1's trial. The items could be picked up when the trial was complete. (This could be several years.)

Detective #1 was interviewed via phone on 01/25/24 at 8:41 AM and explained Nurse #1 was stopped by a patrol officer in the county. The detective said the officer was able to charge Nurse #1 on the spot because she had charges of intercepting a mail truck and was alleged to have stole something from an elderly person that lived nearby that she claimed to be their caretaker. Detective #1 stated after the patrol officer charged Nurse #1, she had received the

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F 602	Continued From page 13 case because Nurse #1 had so many stolen cards in her possession. She explained she was able to locate the victims and had forwarded cases to surrounding counties where Nurse #1 had stolen cards from so the individual counties could press charges against Nurse #1. Detective #1 added in addition to intercepting the mail truck, Nurse #1 was also the subject of a medication theft of another nursing home in another county. Nurse #1 was working through an agency and was accepting jobs in numerous other counties and had last resided in Shelby. Detective #1 stated she located a phone number for Resident #156 and talked to him via phone and as far as he knew no money had been taken and that was why the resident had not reported it to the staff. She explained to Resident #156 his cards were in the safe at the county courthouse. Detective #1 stated she had worked diligently to report Nurse #1 to the board of nursing because "I did not want her near old people." Detective #1 also confirmed that Nurse #1 was not in the Iredell County jail at the time of interview. Resident #156's power of attorney (POA) was interviewed via phone on 01/25/24 at 2:46 PM who stated Resident #156 had told him his driver's license, social security card, and debit card were missing, and he needed to go the bank to get it replaced either in late March 2023 or early April 2023. He further explained Resident #156 did not drive at the time, and he transported Resident #156 wherever he needed to go. When they got to the bank, they went over the charges on his account that Resident #156 was not aware of and did not authorize which were reoccurring charges to a taxi services, online shopping services, and a gas station in nearby county (Gastonia) and the charges started in February	F 602		

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2023 and reoccurred until the card was cancelled in April2023. Resident #156 explained to the bank he just wanted a replacement card and not to close the account because his mind was failing, and he did not want to learn new account numbers. The POA stated the bank replaced Resident #156's debit card and he gave it to the POA to keep in his possession so this would not happen again. The POA stated the bank did an investigation and did replace some of the money that had been taken. He added no one from the facility had contacted him regarding the incident and stated Resident #156 "was very sick and it was easy for someone to come along and take something." The POA stated they had not reported the missing documents, or the alleged fraudulent charges, to the facility because they did not know if the fraudulent charges were made by a facility employee.

An attempt to speak to the agency that Nurse #1 worked for was attempted on 01/25/24 at 10:30 AM.

An attempt to speak to Nurse #1 was made on 01/25/24 via phone at 8:34 AM and again on 01/26/24 via phone at 5:31 PM and was unsuccessful.

The North Carolina Board of Nursing Investigator was interviewed via phone on 01/30/24 at 8:22 AM. She stated that they had received a public complaint regarding Nurse #1 on 05/19/23 alleging the theft of credit cards then on 05/25/23 Detective #1 called and informed them that Nurse #1 had been arrested for being in possession of illegal drugs and stolen credit cards from various other towns. The investigator stated that she called the facility and spoke to Former DON #1

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who reported that Nurse #1 had only worked 2 shifts at the facility. The investigator further explained that Nurse #1 had gone to trial and was convicted of 2 felonies. She also explained that the Board of Nursing recommendation was to suspend Nurse #1's nursing license. However, they could not do that without her acknowledgment and thus far she has made no acknowledgement of their attempts to notify Nurse #1 of the action. The Investigator added that they would take it to a hearing and after the hearing they could formally suspend Nurse #1's nursing licenses. There was no date scheduled for the hearing, but the Investigator stated she hoped by the spring of 2024 they would have date.

An attempt to interview Former DON #1 was made on 01/26/24 at 9:25 AM and again at 5:29 PM without success.

The Administrator was interviewed on 01/25/24 at 11:59 AM. She stated she had received a call from a local detective letting her know Nurse #1 had been pulled over and had in her possession credit cards, driver's license, and social security cards from several elderly folks including one of our residents (Resident #156) on 05/18/23. She explained they ran an employee report from the previous 60 days in the facility and Nurse #1 had not worked in the facility, and it was reported it to the State Survey agency and to the North Carolina Board of Nursing. The Administrator confirmed they had not spoken to any of the other residents but did some education on misappropriation and stated, "there is no way to safeguard his own personal belongings he was alert and oriented."

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The Administrator was notified of Immediate Jeopardy on 01/25/24 at 1:15 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

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

The facility failed to assure that a resident's property was safeguarded, and that staff did not misappropriate the resident's property (driver's license, social security card, and debit card) without the resident's permission or knowledge.

On 5/18/23, the facility Administrator was notified by a Detective from the Iredell County Sheriff's office of an ongoing investigation concerning Nurse #1 who was stopped on a traffic violation and was found to have in her possession several people's bank cards to include Resident #156's driver's license, social security card, and bank card. Resident #156 was interviewed by the Detective and again by the Director of Nursing (DON) on 5/18/23 which revealed that the resident was aware that the identified items were missing but he just thought that he lost or misplaced the items. Resident #156 reported to the Detective and the DON that he had cancelled the bank card and was not worried about the license or the social security card. Resident #156 also reported to DON that he had not reported the missing items to the staff. Review of the resident's medical record revealed that Resident #156 was his own responsible party and had a BIMs of 15 (Highest). Review of the admission agreement, section 9 regarding Personal Possessions, indicated that Resident #156 was

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aware that he could secure his personal property with the facility but preferred to secure his own personal property. In addition, the Detective revealed that all of the identified people who had missing possessions recently had home health care, or a hospital stay. Review of the medical records revealed that Resident #156 was recently in the hospital on 4/12/23 - 4/17/23. Resident #156 was unsure if he might have lost his wallet during his recent hospitalization The Administrator reviewed the resident grievances and there were no additional concerns noted of the current and/or discharged residents related to missing possessions including social security cards, driver's licenses and debit cards. No other resident property was identified by the Detective that belonged to current and/or former facility residents. Review of the findings revealed, however, that the facility failed to provide ongoing education/reminders to all facility staff, interviewable residents and non interviewable resident responsible parties of the facility options to secure resident property. These include lock boxes, the facility safe and utilizing the resident trust system (banking).

On 5/18/23, education was initiated related to Abuse and Neglect to include misappropriation of resident property and Preventing Elder Abuse by the Director of Nursing and the Unit Managers that included all facility staff (licensed nurses, certified nursing assistants, administrative staff, social service, business office, housekeeping/laundry, dietary, therapy, agency staff, weekend staff and prn staff).

All current residents who prefer not to lock/secure their valuable personal possessions are at risk as a result of this deficient practice.

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On 1/26/24 an audit was initiated by the Unit Managers to identify current residents who prefer not to lock/secure their valuable personal items. The identified residents that preferred not to lock/secure their belongings were made aware that lock boxes and/or resident trust fund accounts were available.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

The administrator and the Director of Nursing were educated on 1/26/24 by the Chief Nursing Officer on misappropriation of resident possessions to include the facility options to secure resident possessions such as lock boxes and resident trust accounts. Starting 1/26/24, the education will be initiated by the Staff Development Coordinator and the Unit Managers to all staff, interviewable residents, and non interviewable resident families.

The Administrator will be starting to distribute and mail the letters by 1/27/24 to the residents and/or resident's responsible parties that include education related to resident lock boxes and resident trust accounts to aid in safeguarding resident possessions.
Starting 1/26/24, the Staff Development Coordinator (SDC) will complete education on misappropriation of resident property which includes facility options to secure resident possessions such as lock boxes and resident trust accounts to the facility staff which includes licensed nurses, certified nursing assistants (CNA), certified medication aides (CMA), dietary,

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housekeeping/laundry, therapy staff, maintenance, administrative staff, business office, social services, weekend staff, agency and prn staff.

Starting 1/26/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring all staff to include licensed nurses, housekeeping/ laundry, dietary, administrative, therapy, social services, business office, weekend staff, CNA, and CMA receive the Abuse and Neglect education to include misappropriation of resident funds that include facility options to secure resident possessions. Staff including new hires and prn staff will not be allowed to work without completing this education. The education will be ongoing to include new hires and prn staff. The SDC will be responsible for ensuring the ongoing education is completed.

Effective 1/30/24, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

A credible allegation of immediate jeopardy removal was conducted on 02/01/24. Review of all alert and oriented resident interviews regarding any misappropriation of property were reviewed and education provided to resident, staff, and family was reviewed explaining what misappropriation was, who to report it to, and ways the facility had to safeguard the resident's belongings and personal effects. Interviews with staff across all departments revealed that they had received the education on misappropriation and were able to verbalize what misappropriation was, who to report to, and way that the facility had

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F 602	Continued From page 20 in place to store resident's belongings. The immediate jeopardy removal date of 01/30/24 was validated.	F 602		
F 607 SS=K	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 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, staff, news article	F 607	F607	3/4/24

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review, North Carolina Board of Nursing Investigator, power of attorney, and detective interviews the facility failed to follow their Abuse, Neglect, and Exploitation policy by failing to immediately initiate protective measures to safeguard residents from misappropriation of property and complete a thorough investigation when they received a report from local law enforcement of misappropriation of resident property. On 05/18/23 the facility received a call from Detective #1 informing them that Nurse #1 had been involved in a traffic stop and was in possession of Resident #156's driver's license, social security card, and debit card. There was a high likelihood that Nurse #1 misappropriated the property of other residents leading to the loss of financial resources for residents who resided at the facility at the time of Nurse #1's employment. The facility also failed to thoroughly investigate an allegation of abuse (Resident #28). This deficient practice was for 2 of 3 residents reviewed for allegations of abuse, neglect, and misappropriation of property.

Immediate jeopardy began on 05/18/23 when the facility was made aware by law enforcement that Nurse #1 was found to be in possession of Resident #156's driver's license, social security card, and debit card and failed to immediately implement measures to protect other residents from misappropriation of property. Immediate jeopardy was removed on 01/30/24 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity of E (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education.

F 607

Resident #156 expired 12-13-2023.

No harm was experienced by Resident #28.

As of February 23, 2024, no allegations of abuse have been reported requiring investigation.

On January 26, 2024, the Administrator/Director of Nursing were educated by the Chief Nursing Officer and Regional Director of Operations on thoroughly investigating allegations of abuse, neglect, and misappropriation of resident property.
The Administrator/Director of Nursing will be responsible for initiating protective measure to safeguard residents from misappropriation of property and completing a thorough investigation for allegations of abuse. The Regional Director of Operations/Chief Nursing Officer will ensure a newly hired Administrator or Director of Nursing receive education during facility in-person orientation.
The Regional Director of Operations/Chief Nursing Officer will monitor using a Quality Assurance tool for abuse. The monitoring will include conducting a thorough investigation for misappropriation of resident property and allegations of abuse. The QA monitoring will be conducted biweekly x 12 weeks.
The Regional Director of Operations/Chief Nursing Officer will report the results of the QA monitoring monthly to the Quality

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F 607	Continued From page 22 Example #2 is being cited at a lower scope and severity of D (no actual harm with more than minimal harm that is not immediate jeopardy).	F 607	Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

The finding included:

Review of a facility policy titled, "Abuse, Neglect, and Exploitation" revised on 10/22/23 read in part: Investigation of Alleged Abuse, Neglect, and Exploitation"- an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations included: identify staff responsible for the investigation, exercising caution in handling evidence that could be used in criminal investigation, investigating different types of alleged violations, identifying, and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Focusing the investigation on determining if abuse, neglect, exploitation, and/or misappropriation has occurred, the extent, and cause. Providing complete and thorough documentation of the investigation.

Further review of the policy titled, "Abuse, Neglect, and Exploitation" revised on 10/22/23 read, Protection of Resident: the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation.

1. Review of an Initial Allegation Report from the facility to the Department of Health and Human Services (DHHS) for an allegation of misappropriation of property dated 05/18/23 read in part, Administrator received a call from

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Detective #1 indicating Nurse #1 had been stopped by police and Nurse #1 was in possession of Resident #156's social security card and driver's license. The report was signed by the Administrator.

An email dated 05/18/23 from Detective #1 to the Administrator indicated when Nurse #1 was stopped by law enforcement she was found to have the driver's license and social security card for Resident #156 in her possession along with multiple other bank cards for other elderly people. She has been charged for other cards which were in her possession.

Detective #1 was interviewed via phone on 01/25/24 at 8:41 AM and explained that Nurse #1 was stopped by a patrol officer in the county and the officer was able to charge Nurse #1 on the spot because she had charges of intercepting a mail truck and stole something from an elderly person that lived nearby that she claimed to be their caretaker. Detective #1 stated that after the patrol officer charged Nurse #1, she had received the case because she had so many stolen cards in her possession including those of Resident #156. She explained that she was able to locate the victims and had forwarded cases to surrounding counties that she had stolen cards from so the individual counties could press charges against Nurse #1. Detective #1 stated she had worked diligently to report Nurse #1 to the board of nursing because "I did not want her near old people."

An online news article from the county where the facility was located was posted on 5/21/23 and indicated on 5/16/23 Nurse #1 was charged with multiple offenses to include seven counts of

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taking a financial transaction card.

Review of Investigation Report from the facility to DHHS dated 05/25/23 read in part, facility interviews with staff to include agency staff and resident interviews did not reveal any additional concerns. Nurse #1 was no longer being utilized in the facility. The police were still investigating and the agency that Nurse #1 was with was notified as well. Education to the staff on abuse, but not limited to misappropriation of property was conducted with the facility to include agency staff. The board of nursing will also be made aware of the incident. The report was signed by Former Director of Nursing (DON) #1.

An attempt to interview Former DON #1 was made by phone on 01/26/24 at 9:25 AM and again at 5:29 PM without success.

The investigation folder provided by the facility regarding the incident initially contained the Initial Report and the Investigation report. The facility later provided signature sheets of education completed on 05/18/23 and 05/19/23 regarding abuse, neglect, misappropriation of funds and a submission of complaint to the North Carolina Board of Nursing on 05/26/23 about Nurse #1. No other investigation items were provided from the facility including statements from other residents and/or staff.

The North Carolina Board of Nursing Investigator was interviewed by phone on 01/30/24 at 8:22 AM. She stated that they had received a public complaint regarding Nurse #1 on 05/19/223 alleging the theft of credit cards then on 05/25/23 Detective #1 called and informed them that Nurse #1 had been arrested for being in possession of

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illegal drugs and stolen credit cards from various other towns. The investigator stated that she called the facility and spoke to Former DON #1 who reported that Nurse #1 had only worked 2 shifts at the facility. The investigator further explained that Nurse #1 had gone to trial and was convicted of 2 felonies.

Resident #156's Power of Attorney (POA) was interviewed via phone on 01/25/24 at 2:46 PM who stated that Resident #156 had told him that his driver's license, social security care, and debit card were missing, and he needed to go the bank to get it replaced. The POA stated that he could not recall exactly when they went to the bank, but he guessed it was late March 2023 or early April 2023. When they got to the bank, they went over the charges on his account that Resident #156 was not aware of and did not authorize which were reoccurring charges to a taxi services, online shopping services, and a gas station in nearby county. He revealed the charges started in February 2023 and recurred until the card was cancelled in April. He added that no one from the facility had contacted him regarding the incident."

An initial interview with the Administrator on 01/24/24 at 12:30 PM revealed that she had not done anything regarding the incident, and no investigation was completed on the incident with Nurse #1 because she had been told by her staff that she had never been their employee.

A facility document titled "Timecard Detail Report" for 02/19/23 through 03/04/23 indicated that Nurse #1, an agency nurse, clocked into the facility on 02/23/23 at 7:30 PM and clocked out at 7:07 AM and on 02/24/23 she had clocked in at 11:07 PM and clocked out at 7:07 AM.

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A follow-up interview was conducted with the Administrator on 01/25/24 at 11:59 AM. She stated that she had received a call from a local detective (5/18/23) letting her know that Nurse #1 had been pulled over and had in her possession credit cards, driver's license, and social security from several elderly folks including one of the facility's residents (Resident #156). She explained that they ran an employee report from the previous 60 days in the facility and Nurse #1 had not worked in the facility, so they reported it to the State Survey agency and to the North Carolina Board of Nursing and that was it. The Administrator confirmed that they had not spoken to any of the other residents but did some education on misappropriation. When asked to explain why further investigation was not conducted the Administrator reported the facility believed Nurse #1 obtained Resident #156's driver's license, social security card, and debit card during a hospitalization he had in April of 2023.

The Administrator was notified of Immediate Jeopardy on 01/25/24 at 1:15 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

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

The facility failed to fully implement their abuse policy when the facility failed to interview all staff, other residents, or family members when the facility received a credible allegation of misappropriation by Nurse #1 of Resident #156's

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F 607	Continued From page 27 driver's license, social security card, and debit card on 5/18/23. On 5/18/23, the facility Administrator was notified by a Detective from the Iredell County sheriff's office related to an ongoing investigation concerning Nurse #1 who was stopped on a traffic violation and was found to have in her possession several people's bank cards to include Resident #156's driver's license, social security card, and bank card. Resident #156 was interviewed by the Detective and again by the Director of Nursing (DON) on 5/18/23 which revealed that the resident was aware that the identified items were missing but he just thought that he lost or misplaced the items. Resident #156 reported to the Detective and the DON that he had cancelled the bank card and was not worried about the driver's license or the social security card. Resident #156 also reported to the DON on 5/18/23 that he had not reported the missing items to the staff. Review of the resident's medical record revealed that Resident #156 was his own responsible party and had a BIMS (Brief Interview Mental Status) of 15 (Highest). In addition, the Detective revealed that all of the identified people who had missing possessions recently had home health care or a hospital stay. Review of the medical records revealed that Resident #156 was recently in the hospital on 4/12/23 - 4/17/23. Resident #156 was unsure if he might have lost his wallet during his recent hospitalization. The Administrator reviewed the facility's grievance book on 5/18/23 which revealed no entries related to missing possessions to include social security cards, driver's licenses and debit cards for resident #156 or any current or former resident/responsible party. No other resident items were identified by	F 607		

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the Detective that belonged to current and/or former facility residents. The Administrator was unable to identify any other staff except for Nurse #1. This incident appears to be an isolated incident. After review of the findings, it was determined that the facility failed to interview all the facility staff, the interviewable current residents and the non interviewable resident's responsible parties in the facility to ensure that no other residents may have been affected.

On 5/18/23, education was initiated related to Abuse and Neglect to include misappropriation of resident funds and Preventing Elder Abuse by the Director of Nursing and the Unit Managers that included all facility staff which includes licensed nurses, certified nursing assistants, administrative staff, social service, business office, housekeeping/laundry, dietary, therapy, agency staff, weekend staff and prn staff.
All current residents who prefer not to lock/secure their valuable personal items are at risk as a result of this deficient practice.

On 1/26/24 an audit was initiated by the Unit Managers to identify current residents who prefer not to lock/secure their valuable personal items.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

Administrator and the Director of Nursing were educated on 1/26/24 by the Chief Nursing Officer related to ensuring that Abuse investigations include interviews of all staff, interviewable residents, and non-interviewable resident responsible parties when allegations of

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F 607	Continued From page 29 misappropriation of resident property occur and per facility policy provide complete and thorough records of documentation of the investigation. Starting 1/26/24, the Staff Development Coordinator (SDC) will complete interviews of the interviewable current residents to ensure resident concerns related to misappropriation of resident funds/ property to include driver's license, social security card, and debit cards have been identified and addressed. Starting 1/26/24, the Staff Development Coordinator, Unit Managers, and Nursing supervisors will complete interviews of the facility staff to include licensed nurses, certified nursing assistants (CNA), certified medication aides (CMA), dietary, housekeeping/laundry, therapy staff, maintenance, administrative staff, business office, social services, weekend staff, agency and prn staff to ensure all reports of resident Abuse/Neglect to include misappropriation of resident's property have been reported and follow up completed if needed. Starting 1/26/24, the Staff Development Coordinator (SDC) and the Director of Nursing will be responsible for ensuring all staff to include licensed nurses, housekeeping/ laundry, dietary, administrative, therapy, social services, business office, weekend staff, CNA, and CMA receive the Abuse and Neglect education to include misappropriation of a resident's property. The SDC and/or DON will complete this education for new hires and prn staff to ensure that they receive the training before they return to work. Effective 1/30/24, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged	F 607		

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non-compliance.

A credible allegation of immediate jeopardy removal was conducted on 02/01/24. Education that was completed at the time the facility was made aware of the incident was reviewed along with the education that was currently used to educate all staff on abuse, neglect, and misappropriation. Interviews with residents and staff that were conducted were reviewed and no other significant findings were noted. The letter that was sent to families about misappropriation and the availability of lock boxes was also reviewed. Administrative interviews with the Administrator and Director of Nursing revealed that they had been educated by the Chief Nursing Officer on completing a thorough investigation and retaining proper documentation of the investigation per facility policy. Interviews across all departments revealed that they had been educated on abuse, neglect, and misappropriation of resident property. The staff were able to verbalize what misappropriation was, who to report to, and options the residents had to safeguard their belongings. The immediate jeopardy removal date of 01/30/24 was validated.

2. Review of an Initial Allegation Report from the facility to the Department of Health and Human Services (DHHS) for an allegation of resident abuse dated 10/12/22 revealed the facility was made aware of an allegation of resident-to-resident abuse on 10/11/22 when Resident #28 reported Resident #46 touched her "without her permission".

Review of the facility's 5 working day read in part, "the investigation reveal[ed] that Resident #[28]

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reported that Resident #[46] touched her inappropriately on her breast. Resident #[46] was interviewed and admitted to touching Resident #[28] and reported to social services that he would no do this again. Resident #[28] was placed on 1 to 1 monitoring by staff with a new room change. Resident #[28] continues to be observed for changes in mood and behavior with none observed. Both residents' care plans were reviewed and revised as needed.

Resident #28 was admitted to the facility on 06/11/22 with diagnoses that included vascular dementia, dementia without behaviors, anxiety disorder, and major depressive disorder.

Review of Resident #28's quarterly Minimum Data Set dated 08/16/22 which was prior to the alleged incident revealed her to be cognitively impaired with no psychosis, behaviors, rejection of care, or instances of wandering.

Resident #46 was admitted to the facility on 08/06/22 with diagnoses that included vascular dementia with mood disturbances, anxiety disorder, and history of stroke.

Review of Resident #46's quarterly Minimum Data Set assessment dated 09/28/22 which was prior to the alleged incident revealed him to be cognitively impaired with no psychosis, behaviors, rejection of care, or instances of wandering.

Review of the facility's collective investigations of facility reportable incidents revealed this allegation to not have any additional investigation provided other than the 24 hour and 5 working days reports. There were no written statements from staff, or the residents involved. There were

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also no skin checks or other information regarding the complete and thorough investigation of the allegation.

Review of Resident #46's progress notes revealed a note dated 10/11/22 at 1:05 PM, written by Social Worker #1 that read, "Social Services was made aware of resident inappropriate touching behavior towards a resident. Spoke with resident, nurse, and family. Resident recognized and admit[ted] to inappropriate behavior and informed social services that this behavior will not happen again. [Medical Director] mad aware."

An interview with Social Worker #1 on 01/25/24 at 2:34 PM revealed she had no recollection of the event. After reviewing her note dated 10/11/22, she reported Resident #46 had inappropriately touched another resident. She spoke with Resident #46 about the incident and stated Resident #46 reported he recognized it was inappropriate and would not do it again. Social Worker #1 stated she did not know what the inappropriate touching behavior was and stated she could not define what type of behavior would cause her document "inappropriate touching behavior". Social Worker #1 reported having no further information than what was in her progress note.

An interview with Resident #28 on 01/25/24 at 9:16 AM revealed she had no recollection of the event and stated she felt safe.

An interview with Resident #46 on 01/24/24 at 2:37 PM revealed he had no recollection of the event. He stated he did not know Resident #28 and stated he had never touched anyone

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F 607	Continued From page 33 inappropriately. An interview with DON #3, who was the Director of Nursing at the time the incident occurred, was attempted by phone on 01/25/24 at 4:47 PM, but unsuccessful. An interview with Administrator #3 who was the Administrator at the time of the incident, was completed on 01/25/24 at 5:01 PM. It was revealed that he had no other information to provide to the investigation other than what was in the file at the facility. He stated if there were any written statements or skin checks, they would have been in the folder with the report given to the Division of Health Service Regulation. Administrator #3 also reported he would have sent his complete investigation, which included written statements with his 5 working day report. An interview Administrator #1 on 01/26/24 at 4:14 PM, she reported all facility reportable incidents should have a thorough and complete investigation. She stated the incident between Resident #28 and Resident #46 happened before she arrived and she could not speak to why the investigation was not thorough and complete.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Hospice, diagnoses and range of motion for 2 of	F 641	On January 24, 2024, MDS #2 modified Resident #16 MDS to reflect hospice services. On February 1, 2024, MDS #1 modified	3/5/24

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F 641	Continued From page 34 31 sampled residents (Resident #16 and Resident #60) reviewed. The finding included: 1. Resident #16 was admitted to the facility on 11/01/23 with diagnoses that included Senile Degeneration of the Brain. A review of Resident #16's physician orders dated 11/01/23 revealed the services of Hospice related to a diagnosis of Senile Degeneration of the Brain. A review of Resident #16's care plan initiated on 11/01/23 indicated that he received hospice services related to a terminal illness. A review of Resident #16's admission Minimum Data Set assessment dated 11/13/24 revealed the section on "Health Conditions" did not indicate the Resident had a life expectancy of less than 6 months. An interview was held with MDS Nurse #2 on 01/25/24 at 3:47 PM. The Nurse confirmed the MDS had not been coded correctly and stated, "I just missed it". During an interview with the Director of Nursing (DON) on 01/26/24 at 11:33 AM the DON stated her expectation was for the MDSs' to be coded correctly. 2. Resident #60 was admitted to the facility on 03/29/23 with diagnoses that included cerebral vascular accident (CVA) and hemiparesis. Review of Resident #60's physician orders	F 641	Resident #60 MDS to reflect functional impairment with a diagnosis of hemiparesis. On January 24, 2024, the Reimbursement Clinical Specialist audited current Residents receiving hospice services. Six Residents were identified. All six Residents MDS were coded correctly. On February 6, 2024, the Reimbursement Clinical Specialist audited current Residents with a diagnosis of hemiparesis and 16 Residents were identified. Of the 16 Residents, four Residents MDS were modified to accurately code functional limitations with a diagnosis of hemiparesis. On January 24, 2024, the Reimbursement Clinical Specialist in-serviced MDS #1 and MDS #2 regarding accurately coding the Minimum Data Set (MDS) assessment. The Administrator/Reimbursement Clinical Specialist will ensure any newly hired MDS staff will receive education during facility orientation in-person. The Reimbursement Clinical Specialist/Director of Nursing/Staff Development Coordinator will monitor using a Quality Assurance tool for accuracy of assessments. The monitoring will include a sample of residents receiving hospice services, as well as functional impairment with a diagnosis of hemiparesis. The QA monitoring will be conducted weekly x 4 weeks, biweekly times two weeks, and then monthly times one month. The Reimbursement Clinical Specialist/Director of Nursing/Staff Development Coordinator will report the results of the QA monitoring monthly to	

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F 641	Continued From page 35 revealed an order dated 05/06/23 to apply left hand splint 4-6 hours a day or as tolerated for hemiparesis. Review of Resident #60's revised care plan dated 06/08/23 to apply left hand splint (to improve function) related to hemiparesis. The quarterly Minimum Data Set (MDS) assessment dated 10/18/23 revealed that Resident #60 was cognitively intact. The MDS further revealed that the Resident had no functional impairment in her upper extremities and hemiparesis was not marked as a diagnosis. An interview was held with MDS Nurse #2 on 02/0124 at 10:50 AM. The Nurse confirmed the MDS had not been coded correctly and stated, "I just missed it". The Nurse explained that she reviewed a lot of information on the residents' chart when she completed the MDS, and she just overlooked it. During an interview with the Administrator on 02/01/24 at 3:55 PM the Administrator explained that she expected the MDS to be completed accurately.	F 641	the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	F 661		3/5/24

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F 661	Continued From page 36 (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a discharge summary recapitulation of stay fully and accurately for 1 of 3 residents reviewed for discharges (Resident #155). The findings included: Resident #155 was admitted to the facility on 12/01/22 and was discharged to another skilled facility on 01/20/23. Resident #155's diagnoses included Huntington's disease (incurable neurodegenerative disease), unspecified psychosis, dementia, major depressive disorder, and anxiety. Review of the admission Minimum Data Set	F 661	Resident #155 was discharged from the facility on January 20, 2023. On February 13, 2024, the Administrator completed an audit of Residents who discharged from the facility beginning February 1, 2024. Nine residents were identified. Three Residents were transferred to the hospital. Six Residents discharged home and/or transferred to another Skilled Nursing Facility. All six Residents recapitulation of stays were completed accurately and in it’s entirety. On February 21, 2024, the Director of Nursing in-serviced the Interdisciplinary team, to include Unit Managers, Certified Dietary Manager, Director of Rehabilitation, Social Services, and	

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(MDS) assessment dated 12/06/23 revealed that Resident #155 was severely cognitively impaired for daily decision making and required limited assistance with activities of daily living and total assistance with bathing. The MDS further indicated that there was no active discharge plan for Resident #155 to return to the community at that time.

Review of a physician order dated 12/16/22 read, Do Not Resuscitate (DNR).

Review of a discharge summary dated 01/20/23 revealed that the following sections were not completed upon discharge nursing summary, medication reconciliation, dietary summary, and therapy summary. Review of the social service summary that was completed by the Social Worker (SW) indicated that Resident #155 was a full code.

Review of a physician order dated 01/21/23 read, ok to discharge to memory care unit.

The Social Worker (SW) was interviewed on 01/25/24 at 3:22 PM who stated that discharge planning started upon admission at the facility and then was discussed during their seventy-two-hour meeting and then through care plan meeting. The SW explained that once the resident was ready for discharge to either home, another skilled nursing facility, or assisted living facility she would order any equipment that was needed and set up follow up appointments, and transportation for the resident to their destination. The SW stated she would open the discharge summary recapitulation of stay in the electronic record and complete her sections and the other departments heads would complete their

F 661

Activities Director on completing discharge summary recapitulation of staff fully and accurately. The Administrator/Director of Nursing/Staff Development Coordinator will ensure newly hired Department Head staff will receive education during facility orientation in-person or via telephone prior to working.

The Administrator/Director of Nursing/Staff Development Coordinator will monitor using a Quality Assurance tool for recapitulation of stay. The monitoring will include a sample of discharged residents ensuring their recapitulation of stay was completed accurately and in its entirety. The QA monitoring will be conducted weekly x 4 weeks, biweekly times two weeks, and then monthly times one month. The Administrator/Director of Nursing/Staff Development Coordinator will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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individual sections. Then upon discharge the resident and/or family got a copy of the discharge summary or in this case the receiving facility. The SW stated, "maybe I am responsible for making sure the discharge summary was completed." She further explained that the code status was just an error on her part, and she had not seen the order making Resident #155 a DNR.

The Director of Rehab was interviewed on 01/26/24 at 11:34 AM who stated she completed the therapy section of the discharge summary if the patient was on therapy caseload at the time of discharge. She further explained, if the resident was not on caseload, she was not sure who completed the therapy section of the summary. The Director of Rehab stated that at the time of Resident #155's discharge he was not on therapy caseload, and she would not have completed the therapy section unless directly asked to do so.

Unit Manager #2 was interviewed on 01/26/24 at 11:41 AM who stated that she had worked at the facility for 2 years. She explained that it really depended on the day who completed the discharge summary, she stated it could be her or one of the other nurses just depending on how busy they were. She stated that when she completed the discharge summary, she only completed the nursing sections and the other department heads were responsible for their individual sections. She added that the SW would oversee the completion of the summary and stated that Resident #155 was not on her unit, and she had not completed his discharge summary that would have been Unit Manager #1.

Unit Manager #1 was interviewed on 01/26/24 at 11:52 AM who stated she completed the

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F 661	Continued From page 39 discharge summary in the electronic record for residents that resided on her unit. The summary was opened by the SW and then in the morning meeting she would let the team know when the resident was going to be discharged, and she would go in and complete the nursing sections and other sections if need be. She added the SW ensured that the discharge summary was complete prior to the resident's discharge. Unit Manager #1 explained that Resident #155 discharged before she started with the company and was not aware of who preceded her. The Interim Director of Nursing (DON) was interviewed on 01/26/24 at 12:59 PM who stated that she had been at the facility for only three weeks and believed that the discharge summary was done for all discharges except when discharged to the hospital. The DON stated the SW opened the summary in the electronic record and she expected each department manager to complete their summary as accurately as possible prior to the resident leaving the facility. The DON was unsure what happened to the discharge summary once they were completed.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, family, resident, and staff interviews the facility failed to trim a female resident's chin hairs and toenails (Resident #34) for 1 of 3 residents reviewed for	F 677	F677 On January 24, 2024, Res #34 facial hair and toenails were trimmed by her family member. On January 31, 2024, Res #34	3/4/24

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activities of daily living.

The findings included:

Resident #34 was readmitted to the facility on 10/19/23 with diagnoses that included diabetes, epilepsy, schizophrenia, schizoaffective disorder, hypertension, and chronic pain.

Review of the admission Minimum Data Set (MDS) assessment dated 10/26/23 indicated that Resident #34 was cognitively intact and required partial/moderate assistance with personal hygiene and had no behaviors or rejection of care during the assessment reference period.

Review of a care plan revised on 11/08/23 read in part, Resident #34 had limited physical mobility related to weakness. The interventions included Resident #34 requires one person assistance with hygiene.

Further review of Resident #34's care plan initiated on 11/08/23 read, Resident #34 "refuses to eat, to take medications, and showers and/or being physically/verbally aggressive toward staff such as throwing items, racial comments to staff." The interventions included: administer medications as ordered, empower the resident by allowing choices in mealtime, menu selection, dining location, invite the resident to food related activities, praise all the residents progress, and the resident needs a calm, quiet atmosphere for eating with no unpleasant odors.

An observation and interview were conducted with Resident #34 on 01/22/24 at 2:12 PM. Resident #34 was resting in bed with eyes open. Resident #34 was observed to have chin hairs

F 677

was seen by podiatry at the facility.
On February 23, 2024, the Unit Managers conducted an audit of current female residents for chin hair and all the current residents' toenails. Of the forty-nine female residents, seven were identified with chin hair. Six of the residents were shaved by the nursing staff. One resident prefers not to be shaved and the care plan was updated. The current resident toenail audit completed by the Unit Managers revealed that 3 residents were identified as needing a podiatry referral which was completed.
On February 23, 2024, the Director of Nursing/Staff Development Coordinator/Unit Manager began education with the nursing staff, to include agency, on performing activities of daily living for dependent residents to include shaving facial hair and trimming toenails.
On February 23, 2024, the Director of Nursing/Staff Development Coordinator/Unit Managers will ensure that current staff, who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure newly hired nursing staff, to include agency, will receive education during facility orientation in-person or via telephone prior to working.
The Director of Nursing/Staff Develop Coordinator/Unit Manager will complete observations of the residents for activities of daily living care for dependent residents to include females with chin hair and toenails care for residents three times a

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F 677	Continued From page 41 that were white and long that curled around her chin area approximately a quarter inch long. Resident #34's toenails were also noted to be long approximately a quarter inch long on both feet as they were sticking out from the covers. Her toenails did not appear yellow, brittle, or thick. When Resident #34 was asked about her chin hairs and toenails she stated they both needed to be trimmed because "they looked awful." Resident #34 denied anyone offering to trim her toenails or chin hairs and stated that she would never refuse that care. An observation of Resident #34 was made on 01/23/24 at 12:17 PM Resident #34 was resting in bed her chin hair remained long and curled around her chin and her toenails remained long at approximately a quarter inch long and did not appear yellow, brittle or thick. An observation of Resident #34 was made on 01/24/23 at 9:37 AM. Resident #34 was resting in bed with her eyes open. Her chin hair remained long and curled around her chin area and her toenails remained approximately a quarter inch long and did not appear to be yellow, brittle, or thick. An observation was made on 01/24/24 at 12:00 PM of Nurse Aide (NA) #2 coming out of Resident #34's room. During an interview with Resident #34 at the same time she stated she had just gotten back into bed after getting her hair done. Her chin hair remained long and curled around her chin. Her toenails remained approximately a quarter inch long. Resident #34 had a female visitor in the room and Resident #34 stated that was her family member. During the same observation, NA #2 stated that she had just put	F 677	week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks to include at least 1x on the weekend. The Director of Nursing/Staff Development Coordinator/Unit Manager will report the findings of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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Resident #34 back in bed and put a clean gown on her after her hair appointment and provided incontinent care.

An observation and interview with Resident #34 was made on 01/24/24 at 12:48 PM. Resident #34 was resting in bed dressed in the same clean flannel gown. The family member was not at bedside at this time. Resident #34's chin hair and toenails had been trimmed. Resident #34 stated that her family member had trimmed her chin hair and toenails while she was visiting. Resident #34 stated "I feel so good after getting my hair done, and my toenails cut, and my chin hair shaved" and continued to smile pleasantly.

NA #1 was interviewed on 01/25/24 at 1:43 PM and confirmed that he had taken care of Resident #34 on 01/23/24. He stated that while caring for Resident #34 he would change her brief and put a clean gown on her. NA #1 indicated he had not provided a shower or bed bath that day but had made sure she was clean and dry with a clean gown on. NA #1 stated that he had not noticed Resident #34's chin hair or toenails being long, he stated "it is usually pretty dark when I go in there" referring to Resident #34's room. NA #1 added that if he would have noticed Resident #34's chin hair and toenails being long he could have trimmed them but added "she did not ask me too."

Resident #34's family member was interviewed via phone on 01/25/24 at 2:12 PM. The family member confirmed that she had come in yesterday (01/24/24) to encourage Resident #34 to get up and get her hair done. After she got her back in bed after getting her hair done the family member stated that she had "quite a bit of facial

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hair" so she shaved her and no one had trimmed her toenails, "so I did that as well." The family member stated she would prefer the staff to do it as they were more qualified than she was. The family member stated she had not asked the staff to do it while she was there, she just saw that it had not been done so she did it.

NA #2 was interviewed via phone on 01/25/24 at 5:07 and confirmed that she cared for Resident #34 on 01/22/24 and 01/24/24. She stated that she had given Resident #34 a partial bed bath, provided incontinent care, and got her all cleaned up for the day. NA #2 stated that Resident #34 often refused for her gown to be changed but had let her change it both days she took care of her. NA #2 stated she had not noticed Resident #34's chin hair, but generally she would ask the patient if they want them trimmed and if so "I would definitely do that for them." She confirmed she had not noticed the chin hairs, so she had not asked about it. NA #2 stated that she had noticed Resident #34's toenails. She explained she was not allowed to trim toenails, she could only trim fingernails. NA #2 stated she had reported long toenails in the past but had not said anything about Resident #34's toenails this week to the nurse.

An interview with Unit Manager (UM) #2 was conducted on 02/01/24 at 11:08 AM who stated that Resident #34 resided on her unit. She stated all NAs could shave chin hair and as long as the resident was not a diabetic, they could also trim nails. UM #2 stated that Resident #34 toenails were hard to cut, and the podiatrist had recently been to the facility. She added that if a female resident had long chin hair and toenails, she would expect the staff to take care of them or

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F 677	Continued From page 44 report to the nurse that it needed to be done. The Director of Nursing (DON) was interviewed on 0`1/26/24 at 3:31 PM who stated that direct care staff can certainly shave chin hair and trim toenails as long as the resident was not a diabetic. If the resident was a diabetic the NAs should report that to nurse who could try to trim them or refer the resident to podiatry if needed. The staff are reminded often about providing activities of daily living because making residents feel dignified is a "big thing for me."	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Resident interviews the facility failed to apply a left-hand splint, as ordered by the physician, to	F 688	F688 On February 7, 2024, occupational	3/4/24

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prevent further contracture for 1 of 1 resident (Resident #60) reviewed for limited range of motion.

The finding included:

Resident #60 was admitted to the facility on 03/29/23 with diagnoses that included cerebral vascular accident (CVA) and hemiparesis.

Review of Resident #60's physician orders revealed an order dated 05/06/23 to apply left hand splint 4-6 hours a day or as tolerated.

Review of Resident #60's revised care plan dated 06/08/23 to apply left hand splint (to improve function) related to hemiparesis.

The quarterly Minimum Data Set (MDS) assessment dated 10/18/23 revealed that Resident #60 was cognitively intact and had no behaviors or rejection of care. The MDS also indicated the Resident had no impairment of range of motion of her upper extremities.

A review of Resident #60's 01/2024 Medication Administration Record (MAR) revealed the order for the left-hand splint to be applied for 4-6 hours was initialed as being completed at midnight every day in January including on 01/22/24 by Nurse #11, 01/23/24 by Nurse #10 and 01/24/24 by Nurse #12.

An interview and observation were made of Resident #60 on 01/22/24 at 2:29 PM. The Resident was sitting in her wheelchair visiting with her roommate. Her left hand was noted to be in a fist resting in her lap and when asked if she could open her left hand the Resident stated she could

F 688

therapy evaluated Resident #60 for contracture management. Resident #60 is currently on occupational therapy 5xweekly for 4 weeks with new orders obtained on 2/26/24 for a left-hand palm guard.
On February 19, 2024, the Director of Nursing conducted an audit of current residents requiring splints. Six residents were identified, and the splints were noted to be in place as ordered.
On January 30, 2024, the Director of Nursing/Staff Development Coordinator/Unit Manager began education with the licensed nurses and medication aides, to include agency staff, related to ensuring splints are in place as ordered.
On February 21, 2024, Nurse #11 and Nurse #12 received individual education on ensuring splint are being applied as ordered.
The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure that the licensed nurses and medication aides who have not received this education by March 4, 2024, will not be allowed to work until the education is completed. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure newly hired staff, to include agency, will receive education during facility orientation in-person or via telephone prior to working.
The Director of Nursing/Staff Develop Coordinator/Unit Manager will complete an audit of the residents' splints which include observation of residents' splints placement 3 times weekly to include

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not without using her right hand to open it. Resident #60 explained that she was supposed to wear a splint on her left hand every day, but "they" hardly ever put it on her. The Resident pointed to a mobile multilayered cabinet and stated it was there somewhere. A blue left-hand splint was noted to be on the second storage shelf under some clothing. Resident #60 denied refusing to wear the splint when offered by the staff.

On 01/23/24 at 3:24 PM during an observation and interview with Resident #60 she was sitting in her wheelchair looking out the door in the hallway. The Resident was not wearing her left-hand splint. When asked if she had worn the splint that day the Resident stated "no, no one put it on me today". The splint was noted to be on the mobile shelf where it was the day before.

During an interview with Nurse #6 on 01/24/24 at 4:39 PM the Nurse explained that she often worked with Resident #60 and that she thought the splint was supposed to be put on the Resident when the staff got her up in the morning. Nurse #6 acknowledged the splint order on the MAR was scheduled to be applied at midnight and the Nurse stated, "to be honest I don't try to put the splint on her".

An interview was conducted with Nurse #12 on 01/25/24 at 8:10 AM. The Nurse confirmed that she initialed Resident #60's MAR for 01/24/24 at midnight for the left-hand splint to be applied for 4-6 hours and explained that she had a medication aide that night and sometimes she signed the MAR for the medication aides, and she thought the medication aide put the Resident's splint on. When asked if she checked

1xweekly on the weekend for 12 weeks. The Director of Nursing/Staff Development Coordinator/Unit Manager will report the findings of the QA monitoring monthly for at least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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F 688	Continued From page 47	F 688		

to make sure if what she initialed for was done the Nurse stated no, she just took it for granted that the splint would be put on the Resident.

An interview was conducted with Nurse #11 on 01/25/24 at 3:20 PM. The Nurse confirmed that she worked on 01/22/24 at midnight. The Nurse explained that she was aware that Resident #60 had an order for a left-hand splint to be applied and thought the brown skin sleeves (cloth covering for arms used for protection) that the Resident wore was the splint the order referenced. The Nurse indicated that she did not know the Resident had a blue splint that she was supposed to be applying therefore she had made no attempts to put the Resident's left-hand splint on as ordered.

Multiple attempts were made to interview Nurse #10 who worked 01/23/24 at midnight but the attempts were unsuccessful.

An interview was conducted with the Rehab Manager on 01/25/24 at 11:58 AM. The Manager explained that Resident #60 was admitted 03/29/23 and was on Occupational Therapy case load and was released with an order for a left-hand splint to be applied for 4-6 hours daily (if she tolerated) effective 05/06/23. The Manager indicated the splint was used to prevent further contracture.

During an interview with Unit Manager (UM) #2 on 01/26/24 at 10:16 AM the UM explained that the nurses should be applying the residents' splints if the nurses initial the MARs. She indicated that when the nurses have medication aides, they should be checking behind them to make sure the splints have been applied as

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F 688	Continued From page 48 ordered. An interview was conducted with the Director of Nursing (DON) on 01/26/24 at 11:19 AM. The DON explained that she was made aware of the staff not applying Resident #60's left hand splint as ordered after it was brought to the nurses' attention during the survey. The DON continued to explain that she asked Resident #60 what would be a time of day that she would be agreeable to wearing her hand splint and the time of day was changed to daytime.	F 688		
F 689 SS=E	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 observations, record review, video footage review, staff, and Nurse Practitioner interviews the facility failed to redirect and implement effective interventions to prevent a severely cognitively impaired resident with a history of wandering and exit seeking behaviors and wore a wander guard (alarm used to prevent resident from exiting the building) from exiting the building unsupervised (Resident #155). The facility also failed to effectively supervise and remain with a resident with dementia and had a history of wandering and wore a wander guard who was observed by the Receptionist to exit the	F 689	F689 On January 19, 2023, Resident # 155 exited the facility without supervision. On December 3, 2023, Resident #95 exited the facility without supervision. The current residents who are at risk of elopement with wanderguards are at risk for this deficient practice. On February 23, 2024, the Director of Nursing conducted an audit of current	3/4/24

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building (Resident #95). This deficient practice affected 2 of 2 residents reviewed for accidents.

The findings included:

1. Review of a facility policy titled, "Elopements and Wandering Residents" dated 11/23/23 read, "Elopement occurs when a resident leaves the premises or safe area without authorization (i.e an order for discharge or leave of absence) and /or any necessary supervision to do so. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g internal alert code)."

Resident #155 was admitted to the facility on 12/01/22. His diagnoses included Huntington's Chorea (inherited condition where nerve cells break down over time and cause uncontrolled movements) unspecified psychosis, dementia, major depressive disorder, Alzheimer's disease, restlessness, and agitation.

Review of a wandering assessment completed on 12/01/22 revealed a score of 2 which was low risk to wander.

The admission Minimum Data Set (MDS) assessment dated 12/06/22 indicated Resident #155 was severely impaired for daily decision making and wandered 1 to 3 days during the assessment reference period. The MDS further indicated Resident #155 required one person assistance in locomotion on and off the unit. No restraints or alarms were used during the assessment reference period.

Review of a progress note dated 12/06/22 at 12:19 AM read, "patient very restless, walking up

F 689

residents at risk for elopement with wanderguards and no residents were identified.

On January 26, 2024, The Director of Nursing/Staff Development Coordinator began education for all staff on elopement procedure to include ensuring that residents with wanderguards remain in highly visible areas and staff is redirecting high risk residents away from exit doors. High-risk residents will be placed in the Electronic Medical Record (EMR) task area and on the EMR facility communication board. The Director of Nursing/Staff Development Coordinator will ensure all current staff who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator will ensure newly hired staff, to include agency/contracted staff, will receive education during facility orientation in-person or via telephone prior to working.
The Director of Nursing/Staff Development Coordinator will monitor using a Quality Assurance tool for accident hazards/supervision devices. The monitoring will include identifying residents with wanderguards are in highly visible areas and staff are redirecting them away from exit doors. The QA monitoring will be conducted weekly x 12 weeks. The Director of Nursing/Staff Development Coordinator/Unit Manager will report the results of the QA monitoring monthly to the Quality Assurance

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and down the hallway with an unsteady gait. Patient was redirected multiple times to use his chair or ask for help when needing things. Patient did not express understanding and repeatedly walked the halls without his wheelchair before he went to sleep."

A care plan initiated on 12/14/22 read, Resident #155 "is a wanderer/elopement risk (packing clothes and wanting to go home) related to impaired safety awareness.

A social services assessment dated 12/15/22 indicated that Resident #155's family had reported that while they had him at home, they had found Resident #155 outside going through their cars.

A Situation, Background, Assessment, and Recommendation (SBAR) dated 12/17/22 read; Resident #155 was "anxious and packed up belongings and stated his family was picking him up and became agitated when told family was not coming to get him today." Provider notified and one time order of Clonazepam (antianxiety) 1 milligram (Mg) and hold the scheduled dose at 9:00 PM. If still anxious after 11:00 PM give Clonazepam 0.5 mg.

Review of a progress note dated 12/20/22 at 2:19 PM read, "resident observed propelling himself in wheelchair in hallway with belongings. Resident stated that he wants to go home. Resident was redirected by staff and assisted back to room He also refused care from staff and refused to don clean clothes. His family was called and notified that patient wants to go home. Family will visit on Thursday." (12/21/22) The note was electronically signed by Nurse #14.

Performance Improvement (QAPI) committee for continued compliance and/or revision.

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Review of a progress note dated 12/22/22 at 10:15 AM read, Resident noted with behavior of his packing belongings and attempting to go home. Call to family made. Will place wander guard today and family agreed and stated that resident called him 3-4 times a day requesting to go home. Family indicated that they reassured him that they would visit soon. This note was electronically signed by previous Director of Nursing (DON) #1.

Review of a physician order dated 12/22/22 read; wander guard to left leg, check function and placement every shift.

A wandering assessment completed on 12/22/22 indicated a score of 12 high risk to wander.

Revision of care plan on 12/22/22 stated wander guard in place to left ankle. Interventions included address wandering behavior by walking with resident, redirect from inappropriate areas, engage in diversional activity, administer, and monitor medications, assess for fall risk, assist resident to bed or chair when fatigued, create a rest station in hallway for resident, distract from wandering by offering pleasant diversion, ensure proper fitting of clothes and shoes, and ensure that the area that resident wanders in is safe."

Review of the Treatment Administration Record (TAR) dated January 2023 revealed that Resident #155's wander guard was checked every shift for placement.

Review of a progress note dated 12/28/22 at 2:12 PM read, Resident #155 "refuses care and continues to go to the front door wanting to go

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home." The note was electronically signed by Nurse #13.

Review of progress note dated 12/29/22 at 11:30 AM read, per staff Resident #155's "family visited over the weekend, and he was very adamant about wanting to go home and sitting in main lobby. At times residents blocks the front door, not allowing visitors to enter or exit. Refusing to return to room for care or meals. Receiving max encouragement from staff, requiring several re-approaches." The note was electronically signed by previous DON #1.

Review of a progress note dated 01/19/23 at 9:15 PM read, Staff reported resident was outside in the parking lot area on facility grounds in his wheelchair. Resident was assisted by a staff member and this nurse and was taken to his room. He was alert and oriented. No acute distress, respirations even and unlabored. Skin assessment completed with no injuries or bruising. Resident was placed on one-on-one supervision. Resident put back to bed and was resting at that time. Family and DON updated. The note was electronically signed by Nurse #2.

An observation of the parking lot of the facility was conducted on 01/24/24 at 2:00 PM revealed the area that was identified by Medication Aide (MA) #1 as being the location that she found Resident #155 at on 01/19/23 was on an incline approximately 10 feet from the main residential street which dead ended into the parking lot with a direct turn to the right. Resident #155 was at the direct turn right into the facility on an incline surrounded by woods and homes. The area was approximately 222 feet from the front door of the facility where Resident #155 exited from.

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MA #1 was interviewed on 01/23/24 at 4:02 PM. She stated that from what she could recall she was sitting in the assisted living hall that is adjoined to the skilled facility and was charting when she heard the wander guard alarm go off. MA #1 stated she looked at the alarm panel on the wall directly above her head and saw that it was the front door alarm. MA #1 stated she got up after a brief pause to see if any of the staff closer to the front were going to respond and proceeded to "run through the facility to the front door" and walked outside to see why the alarm was sounding. MA #1 stated she saw Resident #155 in his wheelchair headed up the incline at the exit of the facility near the "main road." MA #2 stated she was afraid Resident #155 was going to get up the hill or someone was going to come over the hill and hit him. MA #1 stated she ran to Resident #155 who was dressed in a gown and asked him if they could go back into the facility because it was cold outside. She stated Resident #155 was agreeable and allowed her to push him back to the building where they went to the assisted living door and banged on the door and Nurse #2 came and let them in. She added that Nurse #2 returned Resident #155 to his room, and she resumed her charting. MA #1 could not recall if Resident #155 had on footwear or what it was if he did.

Nurse #2 was interviewed on 01/23/24 at 3:37 PM and stated she vaguely recalled the event with Resident #155 as it had been over a year since it occurred. She stated she was the charge nurse the night the resident exited the facility. Nurse #2 stated she was not very familiar with Resident #155 but thought she recalled him being a wandering patient. Nurse #2 stated that she

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completed a skin assessment, and he had no injury and she immediately put Resident #155 on one-on-one supervision and notified the management team.

Weather.com, an online weather source indicated that on 01/19/23 the weather in the county where the facility was located had a high temperature of 63 and a low temperature of 45.

Review of video footage from 1/19/23 revealed Resident #155 sitting in his wheelchair at the front desk of the facility messing with papers with the exit door directly across from the front desk approximately 8 feet between the desk and the front door. An unknown staff member was observed to walk by Resident #155 two times without redirecting Resident #155 away from the exit door. Resident #155 was observed to be dressed in a short sleeve t-shirt with a gown either on his lap or on over the t-shirt with black hard sole shoes on. After 1-2 minutes Resident #155 went to the front door of the facility directly across from the front desk and pushed on the door three times and it did not open. Resident #155 was then observed to lift the plastic cover to the emergency door unlock switch and switched it down unlocking the first of two doors. Once Resident #155 flipped the emergency switch down, he pushed the first door and it opened and he propelled himself out the first door and then out the second door and propelled himself towards the right through the parking lot. Approximately 4 minutes after Resident #155 exited the front door MA #1 was seen responding to the door. No other staff were seen in the video footage besides the unidentified staff member and MA #1. The video had a date stamp of 01/19/23 on it.

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Nurse #13 was interviewed via phone on 01/23/24 at 3:04 PM. Nurse #13 confirmed she was taking care of Resident #155 on 01/19/23 when he exited the facility. Nurse #13 explained that she had gone to the vending machine that night to get a snack and was standing outside the vending machine area looking at the windows at the front of the facility and saw a staff member pushing a resident in a wheelchair. She explained she had no idea it was Resident #155. She stated she really thought nothing about it, she just assumed the staff member had taken the resident out for some reason. After Nurse #13 finished her snack, she returned to the unit and Nurse #2 brought Resident #155 to the unit and said he got out the front door and Nurse #13 said "how did that happened I just told" Nurse Aide (NA) #5 to put him in the bed because he had been yawning and appeared sleepy. Nurse #2 explained that she worked at the facility through an agency and was not very familiar with Resident #155 but was aware that he tried to get out of the facility often and wore a wander guard bracelet that she had to check for working order when she worked on third shift. Nurse #13 stated that when Nurse #2 brought Resident #155 back to the unit she did a skin assessment and documented in the record and completed an incident report. She added that she had also notified the Administrator and Medical Doctor about Resident #155 getting outside to the parking lot.

An attempt to speak to NA #5 was made on 01/23/24 at 5:16 PM and was unsuccessful.

A handwritten statement from NA #5 dated 01/19/23 read, "I was working on 600 hall from

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F 689	Continued From page 56 3-11 and was assigned to care for" Resident #155. When the dinner trays had been collected my evening care was done, "I communicated with my nurse to let her know that I was taking my 30-minute break." "I went to grab some food and when I came back, I seen other NA at the nurse's station. So, I went down the hall and sat down to watch the hall." "At that time med aide was pushing Resident #155 in wheelchair saying he was outside." Former DON #3 was interviewed via phone on 01/23/24 at 5:17 PM. She stated that she worked at the facility from September 2022 to May 2023. She recalled that Resident #155 was only at the facility for a short time because the family could not take care of him. Resident #155 was exit seeking and had a wander guard in place. Former DON #3 explained that initially upon admission Resident #155 did not wander but as he stayed and progressed in therapy, he realized that his family was not coming to pick him up and he began to exit seek and liked to sit up front by the front door and talk to the staff that were coming and going. She explained one night after everyone had left up front, he lifted the cover on the emergency door switch and switched it off and then proceeded out the door and went to the far right of the parking lot but did not make it to the main road. She stated, "I don't believe he wanted to leave the facility I believe he just wanted some fresh air." Former DON #3 stated that she cannot recall who called her, but someone called her and told her that Resident #155 had gotten out to the parking lot, and she came in and interviewed all the staff, put someone up front to monitor the door that night, and put Resident #155 on one-on-one supervision. She further stated that she began	F 689		

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education on elopement with all the staff and got the next shift as they came in for work and the Assistant Director of Nursing (also known as Former DON #2) at the time helped with the investigation. In addition to the education and interviews they contacted a company to come out and add additional screamer alarms and install alarms that were key enabled instead of a switch. She also stated she thought the Nurse Practitioner (NP) had assessed Resident #155 the next day and no injuries were noted.

Former DON #2 was interviewed via phone on 01/24/24 at 2:32 PM who confirmed that at the time that Resident #155 eloped she was the ADON, and she heard about the elopement the following morning when she came to work. She stated that Resident #155 did not make it off the property because MA #1 had heard the alarm and went and looked for him and found him and returned him to the facility. She stated she assisted with the education to help Former DON #3 out. Former DON #2 stated that Resident #155 would exit seek more during the times when his family had not come to visit and so we had to put a wander guard on him but generally the aides were easily able to redirect him back to the unit with no issues.

The Administrator was interviewed on 01/24/24 at 10:45 AM, she stated she received a call on 01/19/23 from Nurse #2 about Resident #155 getting outside to the parking lot. She stated she instructed Nurse #2 to do a head-to-toe assessment and place him on one-on-one supervision. The Administrator stated she did not come to the facility that night because she knew that she could review the video footage the next morning when she came to work. She explained

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F 689	Continued From page 58 that when she came in the next morning, she reviewed the video footage, and it showed that Resident #155 lifted the cover to the emergency door switch and flipped to the off position which disabled the door lock, and he opened the door and exited through the first door and because he had a wander guard on the alarm sounded. MA #1 came to the door and walked outside to check the perimeter and found him in his wheelchair. Nurse #2 completed a head count the night before and everyone was accounted for. The Administrator stated that they called the door company to come out and do an assessment of the door system and put the push button screamer alarms on the exit doors at the front, assisted living door, and kitchen door. The ancillary doors screamers were added that can only be disabled with a key that are kept on the medication cart key ring. She added that they educated everyone on the elopement process, what to do if there was an elopement, who to notify, check the residents, update care plan, and how we announce the elopement. The Administrator stated they had conducted a root cause analysis of the situation and determined the root cause to be the emergency switch was easily accessible to the residents, so the facility had the switch removed and push button screamers added to the exit doors. She went on to say that since then they had been monitoring the wander guard system weekly but had not been monitoring the screamer alarms that were installed as a result of the root cause analysis. The Administrator stated that MA #1 did great and did exactly what she was supposed to. On 01/20/23 we had a sister facility that had a memory unit and agreed to take Resident #155 so with family permission Resident #155 was discharged from the facility.	F 689		

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The NP was interviewed via phone on 01/23/24 at 6:12 PM who stated she recalled Resident #155 and did recall being notified that he had gotten outside of the facility one night. She stated she evaluated him the next day and it was an uneventful assessment, and basically, he wanted to go home. The NP stated she was aware that Resident #155 had Huntington's Chorea and was doing well initially but was aware of some behavioral changes he had since his admission. She clarified that she saw and evaluated Resident #155 first thing in the morning when he was his "sharpest" as far as mental state. She further explained that Resident #155 liked to sit in the front lobby and appeared to be watching people come and go, maybe, learning how to get out of the building but to her knowledge this was the only occurrence. The NP stated that no resident should be outside unattended in the parking lot for safety reasons.

Review of a physician order dated 01/20/23 read ok to discharge to memory care unit.

#2. A facility policy titled, "Elopements and Wandering Residents" dated 11/23/23 read, "Elopement occurs when a resident leaves the premises or safe area without authorization (i.e an order for discharge or leave of absence) and /or any necessary supervision to do so. Any staff member becoming aware of a missing resident will alert personnel using facility approved protocol (e.g internal alert code)." .

Resident #95 admitted to the facility on 10/25/23 with diagnoses that included Parkinson's disease, dementia, psychophysiologic insomnia, and repeated falls.

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A physician's order dated 11/08/23 read, wander [alarm] in place on left ankle and ensure placement of wander [alarm] on left ankle every shift for wandering. A physician's order dated 11/09/23 read, ensure function of wander [alarm] every day, one time a day for function of device.

A progress note dated 11/08/23 at 11:17 AM read, "Wander [alarm] placed on resident's left ankle." Resident #95's care plan, last reviewed on 11/09/23 revealed a care plan area for "The resident is an elopement risk/wanderer related to impaired safety awareness." Interventions included address wandering behavior by walking with resident; redirect resident from inappropriate areas; engage in diversional activity.

A wandering assessment completed on 11/13/23 revealed a score of 12 out of 15 which was high risk to wander.
Resident #95's quarterly Minimum Data Set assessment dated 11/15/23 revealed he had moderately impaired cognition with no psychosis, behaviors, or rejection of care. Resident #95 was coded with wandering behaviors occurring 1-3 days during the lookback period. Resident #95 was also coded with having had 2 or more falls since his admission. Resident #95 was coded as using a wander or elopement alarm daily.

Review of a progress note dated 12/01/23 at 10:27 PM read in part, Resident encouraged to lay down and rest because he has been walking/wandering around majority of shift." This note was electronically signed by Wound Nurse #1.

An interview with Wound Nurse #1 on 01/23/24 at

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2:30 PM revealed she had started noting Resident #95's behaviors when she started getting complaints from other residents about Resident #95 wandering in and out of their rooms. She stated she had never observed any exit seeking behaviors. Wound Nurse #1 reported she had heard Resident #95 had exited the building to the courtyard but had no knowledge of him leaving the front of the building.

Review of facility provided incident logs revealed Resident #95 with an elopement on Sunday, 12/03/23.
A review of historical weather data via www.weather.com revealed the high on 12/03/23 in Mooresville, NC was 72 degrees Fahrenheit with a low of 55 degrees Fahrenheit and the skies were partly cloudy.

Review of video footage dated Sunday, 12/3/23 when Resident #95 exited without supervision from the building revealed him to be in gray sweatpants, gripper socks with no shoes, and a red t-shirt. Resident was observed on video to walk up to the door, pause for a second, then push the door open and move into the -vestibule before opening the outside door and walking out of the facility. Receptionist #1 was observed to follow Resident #95 out of the front door and catch up to him several feet from the front door. It appeared that Receptionist #1 attempted to redirect Resident #95 back into the building, but he refused and proceeded to continue to walk to the left, down the sidewalk. Receptionist #1 was observed to not follow Resident #95 but walked back into the facility, put in a numerical code to unlock the front door, and then walk towards the front desk and out of view of the camera. After 5-10 seconds, she was observed to walk back in

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front of the front desk moving to the left and out of vision of the camera.

An interview with Receptionist #1 on 01/23/24 at 2:53 PM revealed she remembered Resident #95 walking out of the front door. She reported she was working at the front desk on 12/03/23 when Resident #95 walked up to the front door, pushed it open, and walked out. She stated Resident #95 wore a wander [alarm] and that the front door normally locked and alarmed if he tried to open it, but that this time, the door did not lock, and the alarm did not sound. Receptionist #1 stated she immediately got up and followed Resident #95 out the front door and took his arm and tried to redirect him back into the facility. She stated Resident #95 said, "No!", yanked away from her and started walking down the sidewalk towards the side of the building. Receptionist #1 reported she ran back into the building, tried contacting the nurses' station via phone and received no answer, so she started walking back to the nurses' station to notify someone that Resident #95 was out of the building. She stated on her way back to the nurse's station she saw Nurse Aide (NA) #5 and called out to her that Resident #95 was outside of the building. She reported NA #7 ran out the side door and was able to get Resident #95 back into the building. Receptionist #1 reported she did not know where NA #7 found Resident #95 or which door they reentered as she went back to the front desk after she notified NA #7 that Resident #95 was outside of the building.

During an interview with the Administrator on 01/23/24 at 12:47 PM, she verified that Resident #95 had exited the facility without supervision on Sunday, 12/03/23.

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Review of a progress note dated 12/04/23 at 10:07 PM read, "Residents' vital [within normal limits]. All medications tolerated. Resident encouraged to resident and ask for assistance. Resident wanders around unit and is redirected as needed. Will continue to monitor." This note was electronically signed by Wound Nurse #1.

During a follow-up interview with Receptionist #1 on 01/24/24 at 2:27 PM, she reported she had not received any elopement training, that she did not know if there was a code she should have called when she saw Resident #95 leave the facility, and that she had been told to notify a nurse if a resident exited the building. She also reported Resident #95 was wearing pajama pants, a short sleeve t-shirt and gripper socks with no shoes.

An interview with NA #7 on 01/23/24 at 3:13 PM revealed she was assigned to Resident #95's hall that day and that Resident #95 had an "energy level of 10" on 12/03/23. She reported Resident #95 wore a wander guard and that he was not safe to be outside of the building without close supervision. She reported shortly after breakfast, she was notified by Receptionist #1 that Resident #95 had gotten outside of the building, so she ran through the side door of the facility to go look for him. NA #7 stated there was no alarm sounding so no one knew Resident #95 had exited the building. She reported that when she exited the side door of the building, she did not immediately see him. She stated there were a few housekeepers in the side parking lot who pointed further down the side of the facility and told her he had continued that direction. She reported she immediately began running further down the side of the building and saw Resident #95 walking away from her. She called out for him to stop at

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F 689	Continued From page 64 which point, NA #7 stated Resident #95 looked back at her and began running from her. NA #7 stated she was finally able to catch up to him around the back of the building and Resident #95 reportedly told her that if he had his tennis shoes on, she would never have caught him. NA #7 stated she was successfully able to bring Resident #95 back into the facility through a back door on the 200 hall. She reported Resident #95 was wearing sweatpants, a t-shirt, and gripper socks with no shoes. NA #7 also stated that Resident #95's feet were wet from walking through water puddles on the ground from rain from the night before. An observation of Resident #95's suspected path of travel with NA #7 revealed he ambulated a total of 494 feet from the front door before he was intercepted and returned to the building. The path Resident #95 took included paved sidewalk, uneven ground, and parking lot with Resident #95 being 15-25 feet from the building. The facility was in a residential area surrounded by homes and a large, wooded area that was accessible by an old farm road by the side parking lot. An interview with Housekeeper #1 on 01/24/24 at 12:28 PM revealed she was working 12/03/23 when Resident #95 exited without supervision from the facility. She reported she remembered the incident because she had taken her 15-minute break and was sitting in her car which was parked near the side of the building near the side door when she noticed Resident #95 walking past her vehicle, down the side of the building. She stated there was no staff member with Resident #95 and she knew he should not have been outside without close supervision. She stated she started to exit her vehicle when she	F 689		

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heard NA #7 calling Resident #95's name. She reported she did not say anything to NA #7 because Housekeeper #2, who was also outside at the time, called out to NA #7, pointed in the direction Resident #95 was headed and told her he had gone that direction (towards the back of the facility).

An interview with Housekeeper #2 on 01/24/24 at 12:52 PM revealed she was sitting in her vehicle which was parked on the side of the building near the side entrance and was on her break, on Sunday, 12/03/24 when Resident #95 caught her eye as he walked past the front of her car. She stated her immediate thought was "why is he out here without anyone". Housekeeper #2 noted that she observed Resident #95 walk through water puddles that were on the ground from rain the previous night, so she got out of her car to try to redirect him back into the building but when she got out of her car, she saw NA #7 exit the side door of the building so she called out to her and told NA #7 which direction Resident #95 was headed. Housekeeper #2 reported NA #7 was successfully able to locate Resident #95 and assist him back into the facility.

An interview with the Maintenance Director on 01/24/24 at 11:58 AM revealed he checked the wander alarm system weekly on Fridays. He stated there were 3 exterior doors that were equipped with the wander alarm system, the front door, the side door near the facility's kitchen, and the door to the assisted living side of the building. He reported he was informed that Resident #95 had exited the building on Sunday 12/03/23 when he arrived to work on Monday, 12/04/23 when the door did not lock or alarm as it was designed to do when a resident who was wearing a wander

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alarm bracelet approached the door. He stated when he tested Resident #95's wander alarm on 12/04/23 it worked as it should, with the door locking and the alarm sounding. He reported he also checked the functionality of the other wander alarms on the residents in the facility that used them and found no issues. The Maintenance Director reported he contacted the wander alarm system company, and they came and extended the distance from the front door that would trigger the door to lock and alarm.

An observation and trial with the wander alarm system on the front door on 01/24/23 at 3:47 PM revealed the door failed to lock and alarm in time when walking at a brisk pace allowing the surveyor to successfully exit the facility before the door locked and alarmed. Additional trials at slower speeds resulted in the door locking and the alarm sounding, which prevented the surveyor from exiting the facility.

An interview with the Administrator on 01/25/24 at 12:36 PM revealed she was familiar with the incident with Resident #95 and was made aware. She reported she did not consider the incident an elopement and insisted that someone from her staff always had their eyes on him from when he exited the front door to when he was brought back into the building. She reported her investigation concluded there was a failure with the wander alarm system that prevented the front door from locking fast enough when Resident #95 approached the front door which allowed Resident #95 to open the door and exit the building. The Administrator reported she felt Receptionist #1 did exactly what she should have when she followed Resident #95 out of the building, attempted to redirect him, then returned

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F 689	Continued From page 67 and requested additional assistance, which in turn, left Resident #95 outside. The Administrator stated that they called the door company to come out and do an assessment of the door system and they moved the signal receiver further from the front door to aide in locking the door before a resident with a wander guard could reach the door.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 27 opportunities, resulting in a medication error rate of 7.41% for 1 of 3 residents (Resident #45) observed during the medication administration observation. The findings included: Resident #45 was admitted to the facility on 10/12/18 with diagnoses that included chronic obstruction pulmonary disease (COPD) and vitamin D deficiency. On 01/23/24 at 8:41 AM Nurse #8 was observed as she prepared 11 medications for administration to Resident #45. The Nurse placed 2 tablets of 400 units each of Vitamin D3 in the medicine cup and gave to Resident #45 then	F 759	F759 Resident #45 was seen on 1/26/2024 by the Nurse Practitioners with no concerns identified. On February 13 and 14, 2024, pharmacy Nurse Consultant conducted medication pass observations with six licensed nurses. All medication errors rates were 0%. On January 25, 2024, the Staff Development Coordinator educated Nurse #8 on Medication Administration. On February 21, 2024, The Director of Nursing/Staff Development Coordinator began educating licensed nurses and medication aides on medication administration. The Director of Nursing/Staff Development Coordinator/Unit Manager	3/4/24

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proceeded to administer one puff of a Spiriva inhaler to the Resident as well.

A review of Resident #45's medical record revealed an order dated 04/01/21 for Vitamin D3 1000 units give one tablet by mouth one time a day for Vitamin D deficiency and an order dated 09/10/22 for Spiriva/Respimat 2.5 micrograms (mcg) / activation (act) Aerosol Solution give 2 puffs by mouth one time a day for COPD.

An interview was conducted with Nurse #8 on 01/23/24 at 1:16 PM. The Nurse knew she only gave the Resident one puff but could not explain why. The Nurse also explained that she did not know that facility had Vitamin D3 in the 1000 unit tablets so she gave the Resident 2 of the 400 unit tablets instead.

On 01/24/24 at 9:31 AM during an interview with the Administrator, she explained that Nurse #8 should have retrieved the Vitamin D3 1000 unit tablet from the medication room because the facility did have the medication in stock. She also indicated the Nurse should have given Resident #45 2 puffs of the inhaler as prescribed by the physician.

On 01/26/24 at 10:33 AM during an interview with Unit Manager (UM) #2 the UM stated she expected Nurse #8 to check the med room for the Vitamin D3 in stock instead of administering the 2 tablets of Vitamin D3 400 units. The UM also stated the Nurse should have given the Resident 2 puffs of the inhaler as directed by the physician.

An interview was conducted with the Director of Nursing (DON) on 01/26/24 at 11:45 AM. The DON explained that there was Vitamin D3 1000

F 759

will ensure all current licensed nurses and medication aides who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator will ensure newly hired licensed nurses and medication aides, to include agency staff, will receive education during facility orientation in-person or via telephone prior to working.
The Director of Nursing/Staff Develop Coordinator will complete medication pass observations twice a week x 4 weeks, weekly x 4 weeks, and then biweekly x 2 weeks to include the weekend licensed nurses and medication aides. The Director of Nursing/Staff Development Coordinator/Unit Manager will report the findings of the QA monitoring monthly for at least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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F 759	Continued From page 69 units in stock in the med room and Nurse #8 should have checked the med room first before she gave the 2 tablets of 400 units. She also indicated the Nurse should have followed the physician's order for the inhaler.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and consultant pharmacist interviews the facility failed to: 1) label medications with the minimum	F 761	F761 On January 24, 2024, Nurse #3 discarded	3/4/24

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information required, including the first and last name of the resident on 1 of 7 medication (med) carts observed (300 Distal); 2) store medications in accordance with the pharmacy storage instructions on 3 of 7 med carts (100 Even, 200 and 200/600 Split); 3) failed to remove lose and unsecure pills/capsules from 6 of 7 med carts (300 Distal, 100 Even, 300 Proximal, 200 Hall, 200/600 Split and 600 Hall) and 4) failed to remove expired medication from the refrigerator in 1 of 2 med rooms (100 Hall) reviewed for medication storage.

The findings included:

The medication storage information sheet from the facility's pharmacy dated 09/2021 revealed Humulin R insulin expired within 28 days of opening.

1. On 01/24/24 at 2:41 PM an observation was conducted on 300 Distal med cart with Nurse #3. Stored on the med cart was a vial of Humulin R insulin that had no resident's name or opening date.

At the time of the observation on 01/24/24 at 2:41 PM Nurse #3 noted the insulin vial and stated there was no resident's name or open date on the vial to determine who it belonged to or when it was opened therefore it should be discarded. The Nurse indicated that she did not know how long the insulin could be kept on the med cart after it was opened. The Nurse explained that all nurses were responsible for keeping the medication carts clean and orderly.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all

F 761 (Plan of Correction)

insulin.
On January 24, 2024, Nurse #4 placed the miacilcin nasal spray upright in the medication cart.
On January 24, 2024, Nurse #6, Nurse #7, and Nurse #8 discarded opened undated DuoNeb foil packs.
On January 24, 2024, Nurse #3, Nurse #4, Nurse #5, Nurse #6, Nurse #7, and Nurse #8 discarded loose pills noted in the bottom of the medication carts drawers.
On January 25, 2024, Nurse #9, discarded the expired medication from med room #1 refrigerator.

On February 23, 2024, The Director of Nursing/Staff Development Coordinator began auditing all seven medication carts for undated, non-resident specific open insulin vials, miacalcin nasal spray not stored upright, DuoNeb foil packs not dated and loose pills in the bottom of the medication cart drawers. All labeling and storage were correct. On February 23, 2024, the Director of Nursing inspected med room #1 and med room #2 refrigerators for expired medications and none were found. The Director of Nursing/Staff Development Coordinator/Unit Managers will clean and organize the medication carts and medication rooms weekly.
On February 21, 2024, The Director of Nursing/Staff Development Coordinator began educating all current licensed nurses and medication aides on labeling and storing of drugs and biologicals. The Director of Nursing/Staff Development

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nurses were responsible for keeping the medication carts clean and orderly which meant they should make sure all medications had the residents' name and open dates on them to determine when the medications should be discarded.

At 4:55 PM on 01/24/24 an interview was conducted with the Consultant Pharmacist who explained that open Humulin R insulin should be discarded after 28 days of opening the vial and each insulin vial should have the resident's name on it.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications have a resident's name and an open date if indicated for that medication to determine the expiration date for the medication. The DON indicated the unit managers should provide oversight for the nurses.

2. The medication storage information sheet from the facility's pharmacy dated 09/2021 revealed Miacalcin Nasal Spray (used to treat osteoporosis) should be stored in the upright position.

a. An observation was made of the 100 Even med cart on 01/24/24 at 2:54 PM along with Nurse #4. The observation revealed Resident #87's Miacalcin Nasal Spray was stored horizontally in the med cart.

An interview was conducted with Nurse #4 on 01/24/24 at 2:54 PM. The Nurse indicated that

F 761 (Plan of Correction)

Coordinator will ensure all current licensed nurses and medication aides who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator will ensure newly hired licensed nurses and medication aides, to include agency staff, will receive education during facility orientation in-person or via telephone prior to working.
The Director of Nursing/Staff Develop Coordinator will complete inspections of the medication carts to include opened insulin vials without opened dates, miacalcin nasal spray stored upright, undated opened DuoNeb foil packs, loose pills in the bottom of medication cart drawers and expired medication in the medication refrigerators twice a week x 4 weeks, weekly x 4 weeks, and then biweekly x 2 weeks. The Director of Nursing/Staff Development Coordinator/Unit Manager will report the findings of the QA monitoring monthly for a least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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she was not aware that Miacalcin Nasal Spray should be stored in the upright position and that each nurse should make sure the medication carts were clean and orderly.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations.

At 4:55 PM on 01/24/24 an interview was conducted with the Consultant Pharmacist who explained that Miacalcin Nasal Spray should be stored in the upright position.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations. The DON indicated the unit managers should provide oversight for the nurses.

The medication storage information sheet from the facility's pharmacy dated 09/2021 revealed Ipratropium / Albuterol inhalation solution (duoneb) vials should remain in the foil pouch and discard in 14 days after opening.

b. An observation was conducted on 01/24/24 at 3:28 PM of 200 med cart along with Nurse #6. The observation revealed an undated open foil pouch containing 9 vials of duoneb solution belonging to Resident #37.

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An interview was made with Nurse #6 on 01/24/24 at 3:28 PM who explained it was each nurse's responsibility to keep the med carts clean and orderly. The Nurse indicated that she did not know the specific storage instructions for open and undated foil pouches for duoneb solutions.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations.

At 4:55 PM on 01/24/24 an interview was conducted with the Consultant Pharmacist who explained that duonebs should remain in the foil pouch after opening and should be discarded in 14 days.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations. The DON indicated the unit managers should provide oversight for the nurses.

c. An observation of 200/600 Split med cart was made on 01/24/24 at 3:42 PM along with Nurse #7. The observation yielded an open and undated foil pouch of duonebs containing 3 vials belonging to Resident #3 and an open and undated foil pouch of duonebs containing 3 vials belonging to Resident #111.

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An interview was conducted with Nurse #7 on 01/24/24 at 3:42. The Nurse explained it was each nurse's responsibility to keep the med carts clean and orderly. She indicated she did not know how long the duonebs could stay in the foil pouches after opening.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations.

At 4:55 PM on 01/24/24 an interview was conducted with the Consultant Pharmacist who explained that duonebs should remain in the foil pouch after opening and should be discarded in 14 days.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations. The DON indicated the unit managers should provide oversight for the nurses.

d. An observation was made of the 600 med cart on 01/24/24 at 3:58 AM along with Nurse #8. The observation yielded 2 open and undated foil pouches of duonebs belonging to Resident #43.

An interview was conducted with Nurse #8 on 01/24/24 at 3:58 PM who explained that it was

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each nurse's responsibility to keep the med carts clean and orderly. The Nurse indicated that she did not know how long the pouches could be used after opening.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations.

At 4:55 PM on 01/24/24 an interview was conducted with the Consultant Pharmacist who explained that duonebs should remain in the foil pouch after opening and should be discarded in 14 days.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were stored according to the pharmacy recommendations. The DON indicated the unit managers should provide oversight for the nurses.

3a. 1. On 01/24/24 at 2:41 PM an observation was conducted on 300 Distal med cart with Nurse #3. The observation yielded 2 white, loose and unsecured pills in the bottom of the med cart drawer.

At the time of the observation on 01/24/24 at 2:41 PM Nurse #3 noted the 2 pills and stated she could not identify the pills or who they belonged to. The Nurse explained that all nurses were

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responsible for keeping the medication carts clean and orderly.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were secure and in a medication card labeled with the resident's name. The DON indicated the unit managers should provide oversight for the nurses.

b. An observation was made of the 100 Even med cart on 01/24/24 at 2:54 PM along with Nurse #4. The observation revealed 17.5 loose and unsecure pills of different shapes, sizes and colors in the bottom of the med cart.

An interview was conducted with Nurse #4 on 01/24/24 at 2:54 PM at the time of the observation. The Nurse explained that she could not identify all the pills because they were not in the medication cards that they were delivered in. The Nurse stated that all nurses were responsible for keeping the med carts clean and orderly.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON

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explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were secure and in a medication card labeled with the resident's name. The DON indicated the unit managers should provide oversight for the nurses.

c. An observation was made on the 300 Proximal med cart on 01/24/24 at 3:21 PM along with Nurse #5. The observation yielded 5.5 pills of different colors, shapes and sizes in the bottom of the med cart drawer. The pills were loose and unsecure.

During an interview with Nurse #5 on 01/24/24 at 3:21 PM the Nurse explained that the pills should be secured in a medication card labeled with the resident's name and the name of the pill.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were secure and in a medication card labeled with the resident's name. The DON indicated the unit managers should provide oversight for the nurses.

d. An observation was conducted on 01/24/24 at 3:28 PM of 200 med cart along with Nurse #6. The observation revealed 35 loose and unsecured pills/capsules in the bottom of the med

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cart drawer.

An interview was made with Nurse #6 on 01/24/24 at 3:28 PM who explained it was each nurse's responsibility to keep the med carts clean and orderly.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were secure and in a medication card labeled with the resident's name. The DON indicated the unit managers should provide oversight for the nurses.

e. An observation of 200/600 Split med cart was made on 01/24/24 at 3:42 PM along with Nurse #7. The observation yielded 8 loose and unsecure pills of different shapes and sizes in the bottom of the med cart.

An interview was conducted with Nurse #7 on 01/24/24 at 3:42. The Nurse explained it was each nurse's responsibility to keep the med carts clean and orderly.

On 01/24/24 at 4:16 PM during an interview with Unit Manager (UM) #1 the UM explained all nurses were responsible for keeping the medication carts clean and orderly.

During an interview with the Director of Nursing

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(DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were secure and in a medication card labeled with the resident's name. The DON indicated the unit managers should provide oversight for the nurses.

f. An observation was made of the 600 med cart on 01/24/24 at 3:58 AM along with Nurse #8. The observation yielded 22 loose and unsecured pills/capsules of different shapes and sizes in the bottom of the med cart drawer.

An interview was conducted with Nurse #8 on 01/24/24 at 3:58 PM who explained that it was each nurse's responsibility to keep the med carts clean and orderly.

During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were secure and in a medication card labeled with the resident's name. The DON indicated the unit managers should provide oversight for the nurses.

The medication storage information sheet from the facility's pharmacy dated 09/2021 revealed Aplisol (solution that aids in the detection of infection with tuberculosis) expired in 30 days after opening.

On 01/25/24 at 9:57 AM an observation was made of the 100 Hall med room along with Nurse #9. The observation yielded 2 vials of Aplisol

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F 761	Continued From page 80 solution that were open and undated. The date on the prescription package was 12/19/23. An interview was conducted with Nurse #9 on 01/25/24 at 9:57 AM. The Nurse indicated she did not know how long the Aplisol solution could remain in the refrigerator after opening and stated regardless the vials should have been dated when opened. An interview was made with UM #1 on 01/25/24 at 10:11 AM. The UM stated she did not know how long the Aplisol solution could remain in the refrigerator after opening. During an interview with the Director of Nursing (DON) on 01/26/24 at 11:49 AM the DON explained that it was each nurses' responsibility to ensure the med carts were clean and orderly which meant they should make sure the medications were secure and in a medication card labeled with the resident's name. The DON indicated the unit managers should provide oversight for the nurses.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)	F 801		3/5/24

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This includes:
§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services

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F 801	Continued From page 82 must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility failed to employ a qualified director of food and nutrition services. The findings included: An interview was conducted with the Interim Dietary Manager #1 (DM) on 1/25/24 at 2:17 PM and revealed that he had taken over as the	F 801	F801 Dietary Manager #2 had not completed the required courses in food safety and management. On January 26, 2024, Dietary Manager #2 was removed from the position and Dietary Manager #1 was employed full-time as the Certified Dietary Manager for the facility.	

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Dietary Manager this week. He stated that the food service company that employed him sent him to this facility on 01/22/24 (Monday) to assume the Dietary Manager position. He stated the previous DM #2 was out sick this week, but she had been working as the DM for this facility for about 8-9 months. DM #1 stated he had worked in the food industry for about 40 years, and he confirmed he had a dietary manger certification. However, he stated he and his organization were aware DM #2 did not have a Dietary Manager certification and he was unsure how long he would be in this current role. He stated DM #2 would be working in the facility as a dietary aide for now.

In a phone interview on 1/30/24 with DM #2, she stated she had been working at the facility since March 2023. DM #2 stated she did not have her Dietary Manager certification, or a Serve Safe certification. She stated she was aware she was supposed to have a certification in her role as a Dietary Manager, but her organization had not enrolled her in a certification program, and she was not able to pay for it on her own.

The Registered Dietician (RD) was interviewed via phone on 01/25/24 03:50 and she stated she worked full time but not at this facility. She explained that she visited the facility once a week and would attend the Interdisciplinary Team meeting when she could.

The Administrator was interviewed on 01/24/24 at 6:15 PM and she confirmed that DM #2 had been working at the facility for about a year and was employed through an outside food service agency. The Administrator also confirmed the RD did not work full-time at the facility. She said

F 801

On January 26, 2024, the Administrator verified the credentials of Dietary Manager #2. Dietary Manager #2 Certified Dietary Manager Certification is current through August 31, 2024. Dietary Manager #2 ServSafe Certification is current through November 4, 2024.
The Administrator will ensure any change in the Food Service Director's position be employed by a qualified director of food and nutrition services.
The Administrator/Director of Nursing/Staff Development Coordinator will monitor using a Quality Assurance tool for food service director. The monitoring will include a change in position and qualifications for the director of food and nutrition services. The QA monitoring will be conducted monthly x 3 months. The Administrator will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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F 801	Continued From page 84 the RD came to their facility once a week. In a follow-up interview with the Administrator which was conducted on 02/01/24 she stated she could not specifically recall being notified of DM #2's lack of any certification.	F 801		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff, and resident interviews, and test tray observation the facility failed to serve food that was palatable in temperature and appearance for 3 of 8 residents reviewed for food (Resident #42, Resident #65, and Resident #107). The findings included: 1a. Resident #42 was admitted to the facility on 07/27/18 with diagnoses that included moderate protein calorie malnutrition, and history of pressure ulcer of left lower back. Review of a physician order dated 02/29/20 read, regular diet, regular texture, and regular thin consistency.	F 804	F804 Residents #42, #65, and 107 were not offered an alternative meal. On February 22, 2024, the Certified Dietary Manager updated Res #42, Res #65 and Res #107 food preferences. On February 12, 2024, the Certified Dietary Manager implemented the tray cart delivery logs for each unit. On February 29, 2024, the facility will implement serving Residents directly from the Main Dining Room kitchenette□s steam table. On March 4, 2024, the Certified Dietary Manager will implement an alternate daily meal selection. This selection will include	3/5/24

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THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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F 804

Continued From page 85

Review of the quarterly Minimum Data Set (MDS) assessment dated 10/13/23 revealed that Resident #42 was cognitively intact and required set up assistance only with feeding.

An observation and interview were conducted with Resident #42 on 01/25/24 at 2:01 PM. Resident #42 had just returned to her room from the dining room. As Resident #42 was going down the hallway to her room she was overheard telling her next-door neighbors that were on the hall, "don't get excited for lunch it was awful." Resident #42 proceeded to her room and stated that the food today "was awful" and the only thing she ate was the carrots they were warm but definitely not hot. The noodles were just plain noodles, were cool and were stuck in the pile that had been plated in the kitchen, "there was no sauce or anything on them" and I don't like fish.

1b. Resident #65 was admitted to the facility on 08/23/23 with diagnoses that included chronic obstructive pulmonary disease, hyperlipidemia, and iron deficiency anemia.

Review of a physician order dated 08/28/23 read, regular diet, regular texture, and regular thin consistency.

Review of the quarterly Minimum Data Set (MDS) assessment dated 12/05/23 which indicated Resident #65 was cognitively intact and required extensive assistance of two person staff for eating.

An observation and interview with Resident #65 were conducted on 01/25/24 at 12:23 PM. Resident #65 was eating lunch in the main dining room and had her lunch tray in front of her. She

F 804

hamburgers, chicken sandwiches, turkey sandwiches, chef salads, chicken tenders, chicken salad sandwiches, french fries and chips.

On February 21, 2024, the Certified Dietary Manager in-serviced the cooks on recipe compliance. On February 26, 2024, the Director of Nursing/Staff Development Coordinator/Unit Manager began in-servicing nursing staff, to include contracted staff, on offering to reheat Residents tray. An ad Hoc Resident Council meeting will be held on March 4, 2024 informing Residents of alternate meal selections. The Director of Nursing/Staff Development Coordinator/Unit Managers will ensure nursing staff, to include agency, who have not received this education by March 5, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure newly hired nursing staff, to include agency staff, will receive education during facility orientation in-person or via telephone prior to working.
The Administrator/Director of Nursing/Staff Development Coordinator/Certified Dietary Manager will monitor using a Quality Assurance tool for nutritive value and preferred temperature. The monitoring will include a sample of Resident interviews on food temperature and staff offering to reheat. The Certified Dietary Manager will monitor using a QA tool for test tray temperatures. The QA monitoring will be conducted weekly x 4

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was taking small bites of fish; she stated it tasted awful, but she was hungry. She added that the food "definitely could have been warmer" but she was hungry so she ate the fish and noodles, but the carrots were so mushy and cold she could not eat them.

An observation and interview with Resident #65 were conducted on 01/26/24 at 12:49 PM. Resident #65 was propelling herself out of the dining room towards her room, she stated she had eaten a few bites of turkey but did not touch her sweet potato. Resident #65 stated "it was not all that warm" and stated she was still hungry. The surveyor asked Resident #65 if the staff warmed up her sweet potato and put some butter on it would she eat it, she replied "yes I am still hungry." The staff were asked to heat up Resident #65's sweet potato and add some butter and Resident #65 was observed sitting in the dining room taking bites of her sweet potato.

1c. Resident #107 was admitted to the facility on 01/12/24.

During an initial interview with Resident #107 on 01/22/24 at 2:33 PM, he reported the food was often cold and tasted terrible and that he had his spouse bring him protein shakes so he did not have to eat the food from the kitchen.

A review of Resident #107's admission Minimum Data Set assessment dated 01/25/24 revealed him to be cognitively intact with no psychosis or behaviors.

Review of Resident #107's physician orders revealed an order dated 01/25/24 read, regular diet, regular texture, and regular thin consistency

F 804

weeks, biweekly times two weeks, and then monthly times one month. The Administrator/Director of Nursing/Staff Development Coordinator/Certified Dietary Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

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F 804	Continued From page 87	F 804		

with unsweetened beverages and condiments.

A follow-up interview with Resident #107 on 01/25/24 at 2:19 PM revealed he received a lunch meal and that it was not good. Resident #107 reported the fish was dry and tough and the noodles were cold and were stuck together. Resident #107 stated the carrots were "ok" but tasted like they were just "served from the can". He stated he ate less than half of his meal before he sent it back and drank one of the protein shakes his spouse had brought him.

An interview with Dietary Manager (DM) #2 was conducted on 02/01/24 at 2:43 PM who stated that she had worked in the dietary department for 2 years and generally she had no complaints about temperature of food. She stated she often had complaints about food being too salty or having too much pepper, but she had spoken to the cooks and the issue had been reported to have gotten better per the residents in resident council. DM #2 stated that she regularly attended resident council and addressed any food issues that were raised during the meeting. DM #2 was not present at the time the test tray was completed but stated a lot of temperatures issues may come from the trays sitting on the hall too long. She stated that DM #1 was taking over the kitchen next week and they would have to work together to find a solution to the cold temperature issues.

DM #1 was interviewed on 02/01/24 at 3:17 PM who stated that he was assuming the manager role this upcoming week and the first thing he was going to do was implement a tray cart delivery log so they knew what time and temperature the food was when it left the kitchen

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F 804		F 804		

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and then what time it arrived at the unit. DM #1 stated that while being at the facility on 02/01/24 he had addressed numerous grievances and 75% of them were about temperature. He planned to enforce recipe compliance and when DM #1 received food complaints he planned on taking the cook with him to talk to the resident so the cook could hear firsthand issues with the food they had cooked. DM #1 stated part of his role was to build a team so that they can serve good hot food to the residents.

2. An observation of the lunch tray line service was conducted on 01/25/24 at 12:00 PM. A test tray was requested for the 600 unit. Each plate was noted to be in the warmer until time of use and then an insulated dome lid and bottom were used with each plate before being plated with food and put on the covered cart to be delivered to the unit. The menu for the day was fish fillet, buttered noodles, and carrots along with a piece of cake for dessert. The food on the steam table was observed to have visible steam coming off it. The test tray was plated at 12:15 PM and was placed on the cart for delivery to the 600 unit. The 600-hall cart left the kitchen at 12:19 PM and arrived at the 600-hall unit at 12:24 PM. At 12:36 PM two staff members were observed to begin passing tray on the 600 hall. The test tray was sampled at 12:46 PM along with the Regional Director of Operations of the contract dietary agency. When the lid was lifted off the tray there was no visible steam but there was visible condensation on the inside of the dome lid. The tray was served with no tarter sauce for the fish fillet and had to be requested. The fish fillet was room temperature at best but had good flavor. The buttered noodles had really good flavor and were warm but definitely not hot. The carrots

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F 804	Continued From page 89	F 804		

were served in a separate bowl on the tray and were definitely the hottest part of the meal. They lacked seasoning but salt and pepper was present for use on the tray.

The Regional Director of Operation for the contract dietary agency was interviewed on 01/25/24 at 1:00 pm who also sampled the test tray and stated the food had good flavor but was at best room temperature. She stated that the tray "could have definitely been warmer." She explained that the current Dietary Manager was out sick, and they had asked her to come to the facility and help out. She added they were sending a fill in dietary manager over to the facility later that that day.

An interview with Dietary Manager (DM) #2 was conducted on 02/01/24 at 2:43 PM who stated that she had worked in the dietary department for 2 years and generally she had no complaints about temperature of food. She stated she often had complaints about food being too salty or having too much pepper, but she had spoken to the cooks and the issue had been reported to have gotten better per the residents in resident council. DM #2 stated that she regularly attended resident council and addressed any food issues that were raised during the meeting. DM #2 was not present at the time the test tray was completed but stated a lot of temperatures issues may come from the trays sitting on the hall too long. She stated that DM #1 was taking over the kitchen next week and they would have to work together to find a solution to the cold temperature issues.

DM #1 was interviewed on 02/01/24 at 3:17 PM who stated that he was assuming the manager

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F 804	Continued From page 90 role this upcoming week and the first thing he was going to do was implement a tray cart delivery log so that we know what time and temperature the food was when it left the kitchen and then what time it arrived at the unit. DM #1 stated that while being at the facility on 02/01/24 he had addressed numerous grievances and 75% of them were about temperature. He planned to enforce recipe compliance and when DM #1 received food complaints he planned on taking the cook with him to talk to the resident so the cook could hear firsthand issues with the food they had cooked. DM #1 stated part of his role was to build a team so that we can serve good hot food to the residents.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		3/4/24

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§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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F 842	Continued From page 92 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Resident interviews the facility failed to maintain accurate medical records related to documentation of a splint application for 1 of 1 resident (Resident #60) reviewed for limited range of motion. The finding included: Review of Resident #60's physician orders revealed an order dated 05/06/23 to apply left hand splint 4-6 hours a day or as tolerated. A review of Resident #60's 01/2024 Medication Administration Record (MAR) revealed the order for the left-hand splint to be applied for 4-6 hours was initialed as being completed at midnight every day in January including on 01/22/24 by Nurse #11, 01/23/24 by Nurse #10 and 01/24/24 by Nurse #12. On 01/25/24 at 8:10 AM a telephone interview was conducted with Nurse #12. The Nurse confirmed that she initialed Resident #60's MAR for 01/24/24 at midnight for the left-hand splint to be applied for 4-6 hours and explained that she had a medication aide that night and she sometime signed the MAR for the medication aides, and she thought the medication aide had put the Resident's splint on. When asked if she checked to make sure if what she initialed for was done the Nurse stated no, she just took it for	F 842	F842 On February 7, 2024, occupational therapy evaluated Resident #60 for contracture management. Resident #60 remains on occupational therapy 5xweek for 4 weeks with new orders obtained on 2/26/24 for a left-hand palm guard. On February 19, 2024, the Director of Nursing conducted an audit of current residents that require splints. Six residents were identified. On February 23, 2024, the Director of Nursing reviewed Medication Administration Records (MAR)/Treatment Administration Records (TAR) documentation and ensured that the splints were in place as ordered for the six identified residents. On January 30, 2024, the Director of Nursing/Staff Development Coordinator/Unit Manager began education with the licensed nurses and medication aides, to include agency staff, related to accuracy of medical records and ensuring splints are being applied as ordered. On February 21, 2024, Nurse #11 and Nurse #12 received individual education on accuracy of medical records and ensuring splints are being applied as ordered. The Director of Nursing/Staff Development Coordinator/Unit Manager	

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F 842	Continued From page 93 granted that the splint would be put on the Resident. When Nurse #12 was asked if she should initial off that a task was done before it was done, and the Nurse indicated she did it to save time. An interview was conducted with Nurse #11 on 01/25/24 at 3:20 PM. The Nurse confirmed that she worked on 01/22/24 at midnight and explained that she knew Resident #60 had an order for a left-hand splint and she thought the brown skin sleeves (cloth covering for arms used for protection) that the Resident wore was the hand splint referenced in the order therefore, that was what she thought she was signing for. The Nurse stated she did not know the Resident actually had a blue hand splint. Multiple attempts were made to interview Nurse #10 who worked 01/23/24 at midnight but the attempts were unsuccessful. During an interview with Unit Manager (UM) #2 on 01/26/24 at 10:16 AM the UM explained that the nurses nor medication aides should initial the treatment or medication records until they have performed the task, and they should only be initialing for tasks that they have completed themselves. On 02/01/24 at 10:30 AM an interview was conducted with the Director of Nursing (DON) who explained the nurses should not be signing off the medical record unless they have completed the task. During an interview with UM #1 on 02/01/24 at 11:05 AM the UM explained the nurses should not document in the residents' medical record that	F 842	will ensure all current licensed nurses and medication aides who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure newly hired staff, to include agency staff, receive education during facility orientation in-person or via telephone prior to working. The Director of Nursing/Staff Develop Coordinator/Unit Manager will review the MARS/ TARS 3 x weekly to include 1x weekly on the weekend for 12 weeks to ensure the accuracy of the medical records and ensure resident splints are being applied as ordered. The Director of Nursing/Staff Development Coordinator/Unit Manager will report the findings monthly for at least 3 months to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

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F 842	Continued From page 94 they have done something if they haven't. An interview with the Administrator on 02/01/24 at 3:55 PM who explained that the nurses knew better than to document in the residents' medical record that they have done something that they have not completed.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		3/4/24

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development, monitoring, and evaluation.

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

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

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

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

§483.75(e) Program activities.

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

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THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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

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

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

§483.75(g) Quality assessment and assurance.

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

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

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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 reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigations that occurred on 01/14/22, 09/20/22 and the recertification and complaint investigations that occurred on 04/15/21 and 07/15/22. This failure was for seven deficiencies that were originally cited in the areas of Resident Assessment (F641), Quality of Life (F677), Quality of Care (F689), Pharmacy Services (F761), Resident Rights (F550 & F584) and Comprehensive Resident Centered Care Plan (F661) and were subsequently recited on the current recertification and complaint survey on 02/01/24. The continued failure of the facility during five federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This tag is cross referred to:
F550: Based on record reviews, and resident and staff interviews, the facility failed to treat residents in a dignified manner when staff spoke to a resident in a disrespectful manner. The resident expressed feelings of anger, upset, and disrespect. This affected 1 of 3 residents reviewed for dignity and respect (Resident #74).

During the recertification and complaint survey

F 867

F867
On, February 23, 2024, the Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance (QAPI) Committee as well as the on-going compliance issues regarding F550, F584, F641, F677, F689, F661 and F761.
All residents have the potential to be affected. On February 23, 2024, the Regional Director of Clinical Services educated the Director of Nursing on the appropriate functioning of the QAPI Committee and the purpose of the Committee to include identifying and correcting repeat deficiencies related to F550, F584, F641, F677, F689, F661 and F761. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of ambassador rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds.
On February 23, 2024, the Regional Director of Operations educated the Nursing Home Administrator on the appropriate functioning of the QAPI Committee and the purpose of the Committee to include identifying and correcting repeat deficiencies related to F550, F584, F641, F677, F689, F661 and F761. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review

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completed on 07/15/22 the facility failed to treat a resident in a dignified manner by not responding to a call light and meeting the resident's request which led to the resident's brief and bed being wet with urine requiring an entire bed change. The resident stated this made her feel unwanted, belittled, and uncared for by everyone except her family or 1 of 2 residents reviewed for dignity.

During the complaint survey completed on 01/14/22 the facility failed to maintain resident's dignity by not providing incontinence care which made the resident feel miserable and embarrassed and failing to assist a resident with toileting that resulted in the resident being incontinent of bowel making her feel embarrassed and ashamed for 2 of 3 residents reviewed for dignity and respect.

During the complaint survey completed on 04/15/21 the facility failed to promote a dignified dining experience by standing over 1 of 2 residents reviewed for dining (Resident #21).

F584: Based on resident and staff interviews the facility failed to unclog a clogged toilet for 1 of 1 resident room (room # 319) reviewed for providing a clean, sanitary, and homelike environment.

During the recertification and complaint survey completed on 07/15/22 the facility failed to maintain walls in good repair in 1 of 5 resident's rooms on 1 of 4 halls.

During the complaint survey completed on 01/14/22 the facility failed to have bath linens available for resident use on 4 of 4 halls.

F 867

of ambassador rounding tools, daily review of Point Click Care documentation, observation during leadership rounds and care plan meetings.
On January 25, 2024, our local Ombudsman in-serviced staff on Residents Rights. On February 8, 2024, the facility hired a customer service liaison to assist with improving communication between the facility and Residents/Responsible parties. On February 26, 2024, the Administrator contacted the QIO and requested assistance in enhancing the facility’s QAPI process. Awaiting follow-up communication.
On February 19, 2024, the Administrator educated the QAPI committee members consisting of, the Director of Nursing, Staff Development Coordinator/Infection Preventionist, Unit Coordinators, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurses, Human Resources coordinator, Unit Secretary, Scheduler, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, Maintenance Director and Environmental Services Director, on the weekly QA review of audit findings for compliance and/or revision if needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remain corrected and/or in compliance with the regulatory requirements is oversight by corporate staff monthly x 3. Corporate oversight will validate the facility’s progress, review

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During the complaint survey completed on 04/15/21 the facility failed to clean sticky bedroom flooring in a residents' room for 1 of 19 rooms. The facility failed to repair walls with exposed metal dented L shaped corner brackets and chipped drywall for 3 of 19 rooms. The facility failed to repair peeling and cracked laminate on nightstands for 2 of 19 rooms. The facility failed to remove a broken toilet seat riser with visible sharp metal railing and 4 plastic pointed brackets that had been bolted to the commode seat for 1 of 19 rooms. These observations occurred on 2 of 4 halls.

F641: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of Hospice, diagnoses, and range of motion for 2 of 31 sampled residents (Resident #16 and Resident #60) reviewed.

During the recertification and complaint survey completed on 07/15/22 the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents reviewed for indwelling catheter, 1 of 5 residents reviewed for unnecessary medication, and 1 of 1 resident reviewed for hospice.

F661: Based on record review and staff interviews the facility failed to complete a discharge summary recapitulation of stay fully and accurately for 1 of 3 residents reviewed for discharges (Resident #155).

During the recertification and complaint survey completed on 07/15/22 the facility failed to complete a comprehensive discharge summary that included a recapitulation of stay for 1 of 1

corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.

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resident reviewed for discharge.

F677: Based on observations, record review, family, resident, and staff interviews the facility failed to trim a female resident's chin hairs and toenails (Resident #34) for 1 of 3 residents reviewed for activities of daily living.

During the recertification and complaint survey completed on 07/15/22 the facility failed to provide incontinence care before the resident wet through her brief and bed linens and provide assistance to maintain personal hygiene for 2 of 5 resident reviewed for activities of daily living.

During the complaint survey completed on 01/14/22 the facility failed to perform incontinence care for 2 of 3 dependent residents sampled for activities of daily living.

During the complaint survey completed on 04/15/21 the facility failed to clean dependent residents' fingernails and failed to trim a dependent residents' toenails. This affected 2 of 11 residents investigated for activities of daily living.

F689: Based on observations, record review, video footage review, staff, and Nurse Practitioner interviews the facility failed to redirect and implement effective interventions to prevent a severely cognitively impaired resident with a history of wandering and exit seeking behaviors and wore a wander guard (alarm used to prevent resident from exiting the building) from exiting the building unsupervised (Resident #155). The facility also failed to effectively supervise and remain with a resident with dementia and had a history of wandering and wore a wander guard

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who was observed by the Receptionist to exit the building (Resident #95). This deficient practice affected 2 of 2 residents reviewed for accidents.

During the complaint survey completed on 09/20/22 the facility failed to prevent a cognitively impaired resident from exiting the facility without supervision for 1 of 3 residents reviewed for supervision to prevent accidents. The resident was severely cognitively impaired, and he exited the front door of the facility in his wheelchair and traveled approximately one quarter mile down the road to a neighborhood where he climbed into a car and was apprehended by local law enforcement using K-9 dogs for suspicion of breaking into a car. The resident was taken to the local emergency room for treatment of dog bites. The facility was unaware the resident had exited the facility until local law enforcement arrived at the facility to confirm his identity and notify the facility that the resident had been taken to the emergency room for treatment. The resident sustained bruises and puncture wounds to his extremities from dog bites.

During the recertification and complaint survey completed on 07/15/22 the facility failed to protect a resident from falling from the bed to the floor during personal care for 1 of 3 resident reviewed for supervision to prevent accidents.

During the complaint survey completed on 01/14/22 the facility failed to provide supervision to prevent a cognitively impaired resident from wandering into resident room and sitting on her bed reviewed for privacy. This occurred for 1 of 1 sampled resident reviewed for accidents.

F761: Based on observations, record reviews,

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F 867	Continued From page 102 staff and consultant pharmacist interviews the facility failed to: 1) label medications with the minimum information required, including the first and last name of the resident on 1 of 7 medication (med) carts observed (300 Distal); 2) store medications in accordance with the pharmacy storage instructions on 3 of 7 med carts (100 Even, 200 and 200/600 Split); 3) failed to remove lose and unsecure pills/capsules from 6 of 7 med carts (300 Distal, 100 Even, 300 Proximal, 200 Hall, 200/600 Split and 600 Hall) and 4) failed to remove expired medication from the refrigerator in 1 of 2 med rooms (100 Hall) reviewed for medication storage. During the recertification and complaint survey completed on 07/15/22 the facility failed to remove expired medications from 2 of 3 medication carts and 2 of 2 medication rooms. The facility also failed to remove unopened insulin pens for 1 of 3 medications carts reviewed. During the complaint survey completed on 01/14/22 the facility failed to secure an unattended medication cart for 1 of 5 observed medication carts. During the complaint survey completed on 04/15/21 the facility failed to remove lose and unsecure pills/capsules, failed to remove debris of paper shavings and rubber bands, failed to remove 2 unopened insulin vials, and failed to remove an opened and undated insulin pen (delivered 12/26/21) from 3 of 5 medication carts reviewed for medication storage. During an interview with Administrator #1 on 02/01/24 at 3:02 PM, she reported her quality	F 867		

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F 867	Continued From page 103 assurance (QA) team met monthly and included the Medical Director, unit managers, administrative staff, and even some direct care staff. Administrator #1 indicated she did not know why there was an identified pattern of repeat deficiencies and reported the identified deficiencies would be included in their quality assurance process moving forward.	F 867		
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 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.	F 883		3/4/24

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F 883	Continued From page 104 §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 the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to included documentation in the medical record of education regarding the benefits and potential side effects of the Influenza immunization for 2 of 5 (Resident #87 and Resident #34) residents reviewed and failed to include documentation in the medical record of education regarding the benefits and potential side effects of the Pneumococcal immunization for 2 of 4 residents reviewed (Resident #65 and Resident #34).	F 883	F883 Res #87 consented and received the influenza vaccination on 1-31-24. The consent was uploaded in their electronic medical record on 2-23-2024. Res #34 received the influenza vaccination on 10-19-23 and documented education on risks versus benefits not found in electronic medical record. Res #34, declined the pneumococcal vaccination, educated on the risks versus benefits, and declination was uploaded in	

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The findings included:

1. Resident #87 was admitted to the facility on 10/18/23.

A quarterly Minimum Data Set (MDS) assessment dated 11/10/23 revealed that Resident #87 was cognitively intact. Further review of the MDS revealed that the Influenza immunization was received outside of the facility.

A review of Resident #87's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the Influenza immunization.

An interview with the Infection Preventionist and the Director of Nursing (DON) was conducted on 01/26/24 at 3:08 PM. The DON explained that the Admissions Director obtained the first information regarding vaccinations upon admission and that was scanned into the medical record then the Infection Preventionist could go in and see what the resident needed or did not need and order any of the needed vaccinations. The Infection Preventionist stated she would get any consents for needed or wanted vaccines that included potential benefits and potential side effects signed prior to administering any of the immunizations and that consent would be scanned into the medical record. The DON explained she had only been at the facility for three weeks and the Infection Preventionist had only been at the facility for a week, and they were just getting things going but the DON stated she planned to get all the consents scanned into the medical records when she could.

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their electronic medical record on 2-26-24.
Res #65 declined the pneumococcal vaccination, educated on the risks versus benefits, and declination was uploaded in their electronic medical record on 2-26-24.
On February 23, 2024, the Director of Nursing/Staff Development Coordinator began auditing current residents' electronic medical records for consents/declinations noting education on the risks versus benefits for the influenza and pneumococcal vaccinations.
Sixty-nine residents are up to date with their influenza vaccinations, educated on risks versus benefits and consents uploaded in their electronic medical records. Thirty-one residents are eligible for the influenza vaccination and will be educated on the risks versus benefits and consents/declinations uploaded into their electronic medical records by 3/4/24 by the Director of Nursing, Unit Manager, and/or the Staff Development Coordinator.
Thirty-five residents are up to date with their pneumococcal vaccinations, educated on risks versus benefits and consents uploaded in their electronic medical records. Sixty-five eligible residents will be offered the pneumococcal vaccination, educated on the risks versus benefits and consents/declination uploaded in their electronic medical records by 3/4/24 by the Director of Nursing, Unit Manager, and/or the Staff Development Coordinator.
On February 26, 2024, the Director of Nursing/Staff Development Coordinator

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2. Resident #34 was readmitted to the facility on 10/19/23.

An admission Minimum Data Set (MDS) assessment dated 10/26/23 indicated that Resident #34 was cognitively intact and had received the Influenza immunization outside of the facility for this Influenza season and the Pneumococcal immunization was up to date.

A review of Resident #34's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the Influenza immunization or the Pneumococcal immunization.

An interview with the Infection Preventionist and the Director of Nursing (DON) was conducted on 01/26/24 at 3:08 PM. The DON explained that the admissions director obtained the first information regarding vaccinations upon admission and that was scanned into the medical record then the Infection Preventionist could go in and see what the resident needed or did not need and order any of the needed vaccinations. The Infection Preventionist stated she would get any consents for needed or wanted vaccines that included potential benefits and potential side effects signed prior to administering any of the immunizations and that consent would be scanned into the medical record. The DON explained she had only been at the facility for three weeks and the Infection Preventionist had only been at the facility for a week, and they were just getting things going but the DON stated she planned to get all the consents scanned into the

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began educating all current Licensed nursing staff/Medical Records Coordinator/Unit Secretary, to include agency staff, on offering and educating on the risks versus benefits for influenza and pneumococcal vaccinations for unvaccinated and eligible residents. Signed consent/declination forms should be uploaded into Residents electronic medical records. The Director of Nursing/Staff Development Coordinator/Unit Manager will ensure newly admitted Residents, if eligible will be educated on the risks versus benefits of vaccinations and consents/declination obtained and uploaded into Residents electronic medical records. Vaccination status will be verified upon admission.
The Director of Nursing/Staff Development Coordinator will ensure all current Licensed nursing staff, to include agency, who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator will ensure newly hired staff, to include agency, will receive education during facility orientation in person or via telephone during prior to working.
The Director of Nursing/Staff Development Coordinator will monitor using a Quality Assurance tool. The monitoring will include a sample review of five (5) current residents electronic medical record for vaccination consent/declination forms with risks versus benefits. The QA monitoring will be conducted weekly x 12 weeks. The

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F 883	Continued From page 107 medical records when she could. 3. Resident #65 was admitted to the facility on 08/23/23. Review of a quarterly Minimum Data Set (MDS) assessment dated 12/05/23 revealed that Resident #65 was cognitively intact and did not receive the Pneumococcal immunization in the facility, was offered and declined. A review of Resident #65's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal immunization. No declination consent was noted in the medical record. An interview with the Infection Preventionist and the Director of Nursing (DON) was conducted on 01/26/24 at 3:08 PM. The DON explained that the admissions director obtained the first information regarding vaccinations upon admission and that was scanned into the medical record then the Infection Preventionist could go in and see what the resident needed or did not need and order any of the needed vaccinations. The Infection Preventionist stated she would get any consents for needed or wanted vaccines that included potential benefits and potential side effects signed prior to administering any of the immunizations and that consent would be scanned into the medical record. The DON explained she had only been at the facility for three weeks and the Infection Preventionist had only been at the facility for a week, and they were just getting things going but the DON stated she planned to get all the consents scanned into the	F 883	Director of Nursing/Staff Development Coordinator will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING ______ B. WING ______	C 02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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F 883	Continued From page 108 medical records when she could.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative	F 887		3/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 887	Continued From page 109 was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 3 of 5 residents reviewed for infection control (Resident #12, Resident #34, and Resident #65). The findings included: a. Resident #12 was admitted to the facility on 03/08/23. Review of a quarterly Minimum Data Set (MDS) assessment dated 12/08/23 revealed that Resident #12 was cognitively intact.	F 887	F887 Res #12 consented and was educated on the risks versus benefits of the COVID-19 vaccination she received on 2-23-24. The consent was uploaded in their electronic medical record on 2-23-2024. Res #34 declined the COVID-19 vaccination, educated on the risks versus benefits, and declination was uploaded in their electronic medical records on 2-26-24. Res #65 declined the COVID-19 vaccination, educated on the risks versus benefits, and declination was uploaded in their electronic medical records on 2-26-24.	

F 887

Continued From page 110

Review of Resident #12's medical record revealed no information that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization.

b. Resident #34 was readmitted to the facility on 10/19/23.

Review of admission Minimum Data Set (MDS) assessment dated 10/26/23 revealed that Resident #34 was cognitively intact.

Review of Resident #34's medical record revealed no information that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization.

c. Resident #65 was admitted to the facility on 08/23/23.

Review of the quarterly Minimum Data Set (MDS) assessment dated 12/05/23 revealed that Resident #65 was cognitively intact.

Review of Resident #65's medical record revealed no information that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization.

An interview with the Infection Preventionist and the Director of Nursing (DON) was conducted on 01/26/24 at 3:08 PM. The DON explained that the Admissions Director obtained the first information regarding vaccinations upon admission and that was scanned into the medical record, then the Infection Preventionist could go in and see what

F 887

On February 23, 2024, the Director of Nursing/Staff Development Coordinator began auditing current residents electronic medical records for consents/declinations noting education on the risks versus benefits of the vaccination. Forty-eight currents Residents are up to date with their COVID-19 vaccination and consents are uploaded in their electronic medical records. Forty-eight residents are COVID-19 booster eligible and consent/declination with education on risks versus benefits were not found. Of the forty-eight Residents, those who consent will be administered the vaccine after obtaining from the pharmacy. Four Residents declined historically without education on the risks versus benefits. One Resident the vaccine is contraindicated. Therefore, fifty-two Residents eligible will be offered, educated on the risks versus benefits of the vaccination, and consent/declination will be uploaded in their electronic medical record.
On February 26, 2024, the Director of Nursing/Staff Development Coordinator began educating all current Licensed nursing staff/Medical Records Coordinator/Unit Secretary, to include agency staff, on offering and signing up unvaccinated and/or booster eligible residents for the COVID-19 vaccine. Signed consent/declination forms should be uploaded to the residents electronic medical records. The Director of Nursing/Staff Development Coordinator will ensure newly admitted residents, if

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	345283	A. BUILDING ______ B. WING ______	C 02/01/2024

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THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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F 887	Continued From page 111 the resident needed or did not need and order any of the needed vaccinations. The Infection Preventionist stated she would get any consents for needed or wanted vaccines that included potential benefits and potential side effects signed prior to administering any of the immunizations and that consent would be scanned into the medical record. The DON explained she had only been at the facility for three weeks and the Infection Preventionist had only been at the facility for a week, and they were just getting things going but the DON stated she planned to get all the consents scanned into the medical records when she could.	F 887	eligible will be offered the vaccination. Vaccination status will be verified upon admission and administered per CDC vaccine scheduling guidelines. The Director of Nursing/Staff Development Coordinator will ensure all current Licensed nursing staff, to include agency, who have not received this education by March 4, 2024, will not be allowed to work until education is completed. The Director of Nursing/Staff Development Coordinator will ensure newly hired staff, to include agency, will receive education during facility orientation in person or via telephone during prior to working. The Director of Nursing/Staff Development Coordinator will monitor using a Quality Assurance tool. The monitoring will include a sample review of five (5) current residents electronic medical record for vaccination consent/declination forms with risks versus benefits. The QA monitoring will be conducted weekly x 12 weeks. The Director of Nursing/Staff Development Coordinator will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345283	A. BUILDING: ______ B. WING ______	2/1/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	**550 GLENWOOD DRIVE MOORESVILLE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 584	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to unclog a clogged toilet for 1 of 1 resident room (room # 319) reviewed for providing a clean, sanitary, and homelike environment. The findings include: Resident # 214 was admitted to the facility on 08/16/24 and signed out against medical advice (AMA) on 08/18/23. A nurse progress note dated 08/16/23 at 9:38 PM, red, in part, Resident #214 was oriented to person, place, time and situation, and she was always continent. A phone interview was conducted with Resident #214 on 01/23/24 at 10:30 AM and she stated that on 08/17/23 when she returned from dialysis in the afternoon around 4:30 PM, the toilet in her shared bathroom

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345283	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 2/1/2024
NAME OF PROVIDER OR SUPPLIER **THE CITADEL MOORESVILLE**	STREET ADDRESS, CITY, STATE, ZIP CODE **550 GLENWOOD DRIVE MOORESVILLE, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 584	Continued From Page 1

was full to the top with feces and wipes. Resident #14 stated on the early evening of 08/17/23, her family member called out over the call bell system and reported the toilet needed plunging and the staff member told them they would send someone to fix the toilet. Resident #214 stated no one ever came to fix her toilet that night or the next day. She stated when her family member arrived the next morning on 08/18/23 and saw that her toilet had not been plunged, they decided to leave the facility.

In a phone interview on 01/26/23 at 4:03 PM with NA #6 she confirmed that she had cared for Resident # 214 on 08/17/23, the evening/night that Resident #214's toilet was clogged. NA #6 stated the maintenance staff leave each day between 4:00 PM and 5:00 PM and they were gone when she became aware of the clogged toilet. NA #6 stated she tried to plunge the toilet about one to two hours after Resident #214 returned from dialysis, but she was unsuccessful. She stated the next morning she notified the maintenance staff of the clogged toilet. NA #6 stated she was not aware that she could call the maintenance staff to come in to fix things during their time off.

Review of the maintenance work log from 08/01/234 through 01/22/24 reviewed no documentation of any work requested or completed in August 2023 for the toilet in room # 319.

In an interview on 01/24/24 at 3:17 PM with the Director of Maintenance, he stated he recalled this event. He stated he was not notified of the clogged toilet until he came into work on 08/18/23 at 7:00 AM. He stated he wished the staff would have called him that night because he and his assistant lived next door to the facility, and they would have come to the facility immediately if they had been notified. He stated he went to fix the toilet on 08/17/23 around 8:00 AM and it was pretty gross. He stated the toilet as filled to the brim with what looked like feces and disposable wipes.

In an interview on 1/24/24 5:36 PM with the Social Worker (SW), she stated she met with Resident #214 in conference room on 08/18/23 as she and her husband were leaving the facility to go home. She stated she could not remember any details about the toilet. She stated Resident #214 didn't want to talk about the toilet and she just wanted to go home. The SW stated she had Resident #214 sign an AMA form and then she went home with her husband.

The Administrator was interviewed on 1/24/24 5:26 PM and she stated she was aware of the toilet issue and had spoken with Resident #214 and her family member before they left the facility AMA. She stated the staff should have called Maintenance, and she would remind the staff that they were allowed to call Maintenance after hours if they were needed in the facility.