STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING ______ B. WING ______	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/24/24 through 6/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QXCY11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/24/24 through 6/27/24. Event ID# QXCY11. The following intakes were investigated: NC00202635, NC00202869, NC00203849, NC00205086, NC00205179, NC00205217, NC00205229, NC00205615, NC00205961, NC00206129, NC00206643, NC00207403, NC00207465, NC00207476, NC00207986, NC00210287, NC00210529, NC00213072, NC00214774, NC00215948, NC00217430, NC00217624, NC00217843, NC00218030, NC00218559, NC00218806. 16 of the 87 complaint allegations resulted in deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		7/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 07/19/2024

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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F 550	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with residents, staff, Ombudsman, Nurse Practitioner, and Medical Director, the facility failed to ensure that the resident could exercise his rights without reprisal from the facility when the facility continued a 1:1 (one-to-one) observation for 30 days after being cleared by the medical provider (Resident #67), failed to empty a half-full urinal from a resident's bedrail during the	F 550	F550 Resident Rights/Exercise of Rights 1a. Resident #67's 1:1 (one-to-one) supervision was discontinued on 1/29/2024. 1b. Resident #43 urinal was emptied on 6/24/2024 by Certified Nurse Aide. Facility Bookkeeper resigned from the facility on 6/24/2024.	

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lunch meal (Resident #43), and failed to maintain dignity when a resident had an uncovered urinary drainage bag with urine visible for public view from the hallway. The reasonable person concept was applied as individuals have the expectation of being treated with dignity and would not want their urine visible to visitors, staff, and other residents (Resident #87). This deficient practice was for 3 of 4 residents reviewed for dignity.

The findings included:

1. Resident #67 was admitted to the facility on 3/18/20 with diagnoses which included stroke and depression.

The social service note dated 12/28/23 at 4:29 pm written by the previous Social Worker revealed Resident #67 was issued a 30-day notice of discharge from the facility. Resident #67 was noted to report he would find a way to hurt himself so he would meet the level of care required to remain at the facility. The note further noted that Resident #67 was placed on a 1:1 observation for safety.

Review of the 30-day discharge notice dated 12/28/23 revealed Resident #67 no longer met the skilled nursing facility (SNF) level of care needs due to the health improvement. Resident #67 was noted for pending discharge on or before 1/27/24.

A physician order dated 12/28/23 for Resident #67 to be placed on 1:1 supervision for 30 days for safety.

The Nurse Practitioner (NP) encounter note dated 12/29/23 revealed Resident #67 was seen by the

F 550

1c. NA #2 was immediately educated on privacy covers for urine collection bags on 6/27/2024 by RN Unit Manager. NA #2 and RN Unit Manager placed a privacy cover on Resident #87's indwelling foley catheter urinary drainage bag.

2a. All residents with 1:1 supervision have the potential to be affected. Facility currently has no residents on 1:1 supervision.
2b. All residents that utilize urinals have the potential to be affected. Facility wide urinal audit completed to identify residents that utilize urinals by the Director of Nursing (DON) on 7/16/2024.
2c. All residents with indwelling foley catheters have the potential to be affected. Audit completed on all current residents with indwelling foley catheters to ensure urinary drainage bags have privacy covers by DON on 7/16/2024.

3a. Education provided to all licensed/certified nursing staff to include FT, PT, PRN and agency staff on facility policies NSG266 Enhanced Patient Supervision: Continuous 1:1 and OPS206 Resident Rights Under Federal Law. Education completed by Nurse Practice Educator (NPE) and/or designee by 07/21/2024. Education will be provided to all new clinical and administrative hires during their orientation period by NPE and/or Designee.
3b. Education provided to all licensed/certified nursing staff to include

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NP for follow-up to the threat to harm self. The NP noted that Resident #67 reported he had no intention or plan to harm himself and he stated the reaction was based on the receipt of the 30-day discharge notice he received from the facility. The NP further noted that Resident #67's did not require 1:1 observation monitoring as he was not a threat to himself or others. The NP further noted that the facility allowed Resident #67 to sign out of the building without 1:1 monitoring and that if Resident #67 was to harm self he would do it at any time when left alone.

A telephone interview was conducted on 6/27/24 at 9:47 am with the Nurse Practitioner (NP) who revealed she saw Resident #67 on 12/29/23 and determined he did not require the 1:1 observation because he was not a harm to himself or others. The NP stated she notified the facility, and the facility received her documentation from her visit with Resident #67 on 12/29/23 and would have been able to read her note that also stated the 1:1 observation was not needed. The NP stated she was later told by the facility that Resident #67's 1:1 observation was "more or less a safety measure" and she left the decision up to the facility but wanted it understood that Resident #67 did not require the 1:1 observation. She stated Resident #67 had a history of behaviors that would come and go with increased depression at times, so he was closely followed by psychiatric services weekly and she stated he was not a harm to himself or others.

The Minimum Data Set (MDS) quarterly assessment dated 1/02/24 revealed Resident #67 was cognitively intact and was not coded for behaviors. Resident #67 had a Patient Health Questionnaire 9 (a tool used to measure the

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FT, PT, PRN, agency staff, and facility administrative staff on facility policies IC201 Cleaning and Disinfecting and OPS206 Resident Rights Under Federal Law. Education completed by Nurse Practice Educator (NPE) and/or designee by 07/21/2024. Education will be provided to all new clinical and administrative hires during their orientation period by NPE and/or Designee.

3c. Education provided to all licensed/certified nursing staff to include FT, PT, PRN and agency staff on facility policies OPS213 Treatment: Considerate and Respectful and OPS206 Resident Rights Under Federal Law. Education completed by Nurse Practice Educator (NPE) and/or designee by 07/21/2024. Education will be provided to all new clinical and administrative hires during their orientation period by NPE and/or Designee.

4a. Director of Nursing (DON) and/or designee will review residents placed on 1:1 supervision to ensure adherence to facility policy NSG266 Enhanced Patient Supervision: Continuous 1:1 as well as adherence to facility policy OPS206 Resident Rights Under Federal Law (starting 7/22/2024), weekly x12 weeks.

4b. Director of Nursing (DON) and/or designee will audit residents identified with utilization of urinals to ensure proper cleanliness and storage per resident preference daily x2 weeks (starting 7/22/2024) 10 random residents bi-weekly x4 weeks, then 10 random residents x1

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severity of depression) score of 0 (no depression symptoms).

The Psychiatric Follow-up Evaluation note dated 1/05/24 revealed Resident #67 was seen by the Psychiatric NP related to recent expression of suicidal ideation. The Psychiatric NP noted that Resident #67 had an on-call provider visit on 12/29/23 that cleared Resident #67 of the 1:1 observation but he remained on 1:1 observation at the time of the visit. The Psychiatric NP reported Resident #67 seemed frustrated and demoralized with poor eye contact, less talkative than previous visits, and appeared to have been crying. The Psychiatric NP further noted Resident #67 reported he felt the process of discharge was retaliation for complaints that he (Resident #67) made and that he had made some enemies at the facility. The Psychiatric NP noted Resident #67 denied any plans to harm himself and denied suicidal or homicidal ideation. The Psychiatric NP noted the treatment plan was discussed with nursing home staff.

Review of the Interdisciplinary Team (IDT) meeting notes dated 1/09/24 and completed by the previous Assistant Director of Nursing revealed Resident #67 was reported to have verbal behaviors towards staff and the 1:1 observation would continue for safety and behaviors. The IDT note did not list any self-harm or suicidal ideation by Resident #67.

The Psychiatric Follow-up Evaluation note dated 1/11/24 revealed the Psychiatric NP met with Resident #67 who denied any thoughts or plans of self-harm or harming others. The Psychiatric NP noted she would follow-up in one week. The Psychiatric NP noted the treatment plan was

F 550

month.
4c. Director of Nursing (DON) and/or designee will audit all residents with indwelling foley catheters to ensure urinary drainage bags have privacy covers daily x4 weeks (starting 7/22/24), bi-weekly x2 weeks, and monthly x1 month.

Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.

The Director of Nursing will be responsible for the implementation of the plan.

Date of Compliance: 07/21/2024

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F 550	Continued From page 5 discussed with nursing home staff. The nursing progress note dated 1/14/24 at 5:43 pm by Nurse #8 revealed Resident #67 reported he felt he was unfairly made to keep sitter and had no plans to harm self. An attempt to interview Nurse #8 on 6/27/24 at 8:53 am was unsuccessful. The IDT meeting notes dated 1/16/24 and completed by the previous Assistant Director of Nursing revealed Resident #67 was noted for verbal and aggressive behavior towards staff and was determined 1:1 observation would continue. The IDT note did not list any self-harm or suicidal ideation by Resident #67. The Social Service note dated 1/18/24 revealed the facility rescinded the 30-day discharge notice for Resident #67. Review of the 30-day discharge rescind notice dated 1/18/24 Resident #67's 30-day discharge was rescinded due to ineligibility to qualify for special assistance Medicaid. An attempt to interview the previous Social Worker on 6/27/24 at 8:57 am was unsuccessful. The Psychiatric follow-up evaluation visit note dated 1/19/24 revealed Resident #67 was seen for routine follow-up and at request of Ombudsman for increased depression and poor sleep reported by Resident #67. The Psychiatric NP noted that Resident #67 was still being monitored 1:1 per facility administration after making threat to harm self when initially presented with the 30-day discharge notice. The	F 550		

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F 550	Continued From page 6 Psychiatric NP reported Resident #67 denied any thoughts suicidal or homicidal ideation, denies plans of self-harm, and verbally contracts for safety. The Psychiatric NP noted the treatment plan was discussed with nursing home staff. The Psychiatric follow-up visit note dated 1/27/24 revealed Resident #67 was seen by the Psychiatric NP and was noted that Resident #67 denied any thoughts or plans of self-harm and verbally contracted for safety. The Psychiatric NP noted the treatment plan was discussed with nursing home staff. An attempt to interview the Psychiatric NP on 6/27/24 at 10:36 am was unsuccessful. The facility reported they were unable to provide contact information for the previous Assistant Director of Nursing, so an interview was unable to be conducted. Reivew of the nursing progress notes dated 12/28/23 through 1/29/24 revealed no documentation that Resident #67 had voiced any thoughts or desire to harm himself. Review of the 1:1 observation records dated 12/28/29 through 1/29/24 revealed Resident #67 did not express suicidal ideation or any reports to harm self. The physician order for Resident #67's 1:1 supervision was discontinued on 1/29/24. During an interview on 6/24/24 at 2:10 pm Resident #67 revealed he was upset by the facility giving him a 30-day discharge notice and he said things he should not have said. Resident	F 550		

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F 550	Continued From page 7 #67 stated after he made the statement that he would harm himself he was put on 1:1 observation with a staff member sitting outside his door 24 hours a day for 30 days. Resident #67 stated he was frustrated because the staff watched everything he did and followed him around the facility which made him feel like he had no privacy, and he was being treated like a child when he was a grown man. Resident #67 stated when he asked the Administrator when the 1:1 observation would be removed, he stated the Administrator spoke to him in a rude manner and told him he would not come off the 1:1 observation until he was discharged from the facility. Resident #67 stated he felt the facility kept the 1:1 observation for the entire 30 days out of spite and because he was vocal about issues at the facility which he stated made the Administrator mad. Resident #67 stated he felt like he was being punished by the Administrator because he would not allow him to come off the 1:1 observation because he wanted him to discharge. Resident #67 stated he called the Ombudsman and she met with him about the 30-day discharge notice and 1:1 observation. Resident #67 stated the Ombudsman went and talked to the Administrator, but nothing changed with the 30-day discharge notice or the 1:1 observation. Resident #67 reported the facility allowed him to go out of the facility by himself as normal without 1:1 observation, but he did not like that he was constantly being watched by staff when he was in the facility. Resident #67 stated he felt disrespected by the Administrator for speaking his (Resident #67) opinions about things he did not think were right at the facility. A telephone interview was conducted on 6/27/24 at 10:22 am with the Ombudsman who revealed	F 550		

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she spoke with Resident #67 after he made the statement (unable to recall the date at this time) that he would harm himself and Resident #67 stated he only said that so they would not discharge him. The Ombudsman stated she believed Resident #67's threat to harm himself was not a serious threat and that Resident #67 was in a very bad situation which he felt he had very little control over when he received the 30-day discharge notice. The Ombudsman stated she believed Resident #67's report that the facility kept Resident #67 as a 1:1 observation so he would agree to discharge from the facility. The Ombudsman stated Resident #67 reported increased depression with 1:1 observation in place and she discussed with Resident #67 a need for a visit with the psychiatric provider to discuss the situation and he agreed. The Ombudsman stated she met with the Administrator and requested psychiatric services to see resident an additional time due to Resident #67's reported increased depression due to the 1:1 observation, but she felt the Administrator was not accepting of her concerns regarding Resident #67's mental health.

A telephone interview was conducted on 6/27/24 at 11:07 am with the Medical Director who revealed he did not see Resident #67, but he approved the 1:1 observation order based on the recommendation of the facility due to report of self-harm by Resident #67. The Medical Director stated that he did not recall if he was notified that the NP cleared Resident #67 from the 1:1 observation on 12/29/23 but stated the NP had the authority to remove the 1:1 observation. The Medical Director stated he did not have to personally give permission for the facility to remove the 1:1 observation order when it was

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determined by the NP to be no longer needed. The Medical Director stated if the NP notified the facility in writing or verbal that Resident #67 no longer required the 1:1 observation the facility should have discontinued the order.

An interview was conducted on 6/26/24 at 3:32 pm with the Director of Nursing (DON) who revealed Resident #67 was given the information that he was going to be transferred and he did not want to leave so he made the threat to harm himself to stay at the facility. She stated he was placed on a 30-day 1:1 observation to match his 30-day discharge notice so he would be safe until he discharged. The DON stated Resident #67 reported to her that he did not like staff sitting with him because he did not need the 1:1 observation, but the DON stated the 1:1 observation was required for his safety due to his verbalization to hurt himself. She stated Resident #67 was able to come and go from the facility as he desired without supervision because he signed himself out when he left the facility, and he was able to leave his room when he wanted. The DON stated she did not recall seeing the NP visit note of 12/29/23 when he was cleared from the 1:1 observation and she did not recall speaking to the NP about it. The DON stated she may not have been at the building at that time so the NP may have spoken to the previous Assistant Director of Nursing (ADON). The DON stated she did not recall reviewing the Psychiatric NP visit notes that Resident #67 denied feelings of self-harm until this surveyor asked about the note. The DON stated she recalled seeing the note about the 30-day discharge notice being rescinded but she was unable to state when she saw the note or why the 1:1 observation was not discontinued at that time since Resident #67 was no longer being

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transferred. The DON confirmed there was no documentation during the 1:1 observation period that Resident #67 made statements of self-harm and confirmed staff did not verbally report any concerns regarding self-harm from Resident #67. The DON stated the decision to keep Resident #67 on the 1:1 observation for the 30-day period was for his safety even though there was no further documentation or reports regarding self-harm Resident #67 still had behaviors towards staff like yelling and cursing. The DON stated she did not re-evaluate or ask for the Medical Director to re-evaluate the need for the 1:1 observation to continue for Resident #67 during the 30-day period.

During an interview with the Administrator on 6/27/24 at 9:56 am he revealed when Resident #67 asked about how long the 1:1 observation would last he told Resident #67 it would be in place until he discharged from the facility. The Administrator stated he did not feel he was rude to Resident #67, but just stated the information clearly. The Administrator stated he was aware Resident #67 did not like being on the 1:1 observation but stated he did not make the clinical decision for Resident #67 to remain on the 1:1 observation since he was not clinical. The Administrator stated it was not reported to him at that time that the NP stated Resident #67 did not require the 1:1 observation but he stated the Medical Director was responsible for making that decision not the NP. The Administrator stated he was sure he was eventually told about the 1:1 observation not being needed for Resident #67, but he was not sure who told him or when. The Administrator stated that the NP and the Psychiatric NP were like consultations that gave recommendations, and the Medical Director

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ultimately made the care decisions. The Administrator was unable to say if the Medical Director was notified of the NP and the Psychiatric NP visit notes which Resident #67 was determined not to be at risk for self-harm.

2. Resident #43 was admitted to the facility on 11/11/19 with diagnoses that included hypertension, spinal stenosis (the space inside the backbone is too small) and lymphedema (a chronic condition that causes localized swelling in the body due to a buildup of lymph fluid).

Resident #43's most recent Minimum Data Set assessment dated 5/31/24, a quarterly assessment revealed he was cognitively intact. He was assessed as requiring substantial assistance for bed mobility and transfers.

During an observation and interview on 6/24/24 at 12:05 PM a half-full open urinal was observed on Resident #43's right bed rail. A urine smell was present. Resident #43 stated his urinal was not emptied as often as he would like. He reported that he feels the urinal has the potential to attract pests and he can smell the urine. Resident #43 stated he uses the urinal without assistance.

An observation and interview were conducted on 6/24/24 at 1:03 PM. There was a open half-full urinal on the right bed rail of Resident #43's bed. There was a urine smell present in the room. Resident #43 was eating his lunch while sitting up in bed. He reported it was not appetizing to eat his lunch while being able to smell the urine in the urinal.

An interview was conducted with Nurse Aide #3 on 6/24/24 at 1:19 PM. She stated Resident

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#43's urinal should have been emptied prior to his lunch tray being delivered. NA #3 stated she did not deliver Resident #43's lunch tray and was unfamiliar with the staff member who did so. She emptied Resident #43's urinal.

During an interview with Nurse #9 on 6/24/24 at 1:20 PM she stated Resident #43's urinal should have been emptied prior to delivery of Resident #43's meal tray.

During an interview with the facility Bookkeeper on 6/24/24 at 1:20 PM she stated she delivered Resident #43's lunch tray. She stated she was unaware that urinals should be removed from bedrails and emptied prior to the delivery of meal trays.

During an interview with the facility Administrator on 6/24/31 at 1:31 PM he reported urinals should be emptied prior to the delivery of meal trays. He stated the facility Bookkeeper should have ensured Resident #43's urinal was emptied prior to delivering his meal tray. The Administrator stated he would ensure all facility staff who deliver meal trays are educated on the need for urinals to be emptied prior to the delivery of meal trays.

3. Resident #87 was admitted to the facility on 8/03/21.

Resident #87's Minimum Data Set (MDS) dated 5/23/24 revealed he was severely cognitively impaired, had no speech and did not understand others, and had an indwelling urinary catheter.

Review of Resident #87's comprehensive care plan initiated 7/6/22 revealed he required an

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F 550	Continued From page 13 indwelling Foley catheter due to urinary retention and neuromuscular dysfunction of his bladder. One intervention listed was to provide a privacy bag for the urine collection bag. Observations on 06/24/24 at 10:29 A.M., 06/25/24 at 12:29 P.M., 06/26/24 at 3:37 P.M, and 06/27/24 at 12:07 P.M. revealed Resident #87's Foley catheter collection bag hanging on the left side of his bedframe, which was towards the door. The urine in the collection bag was visible. In an interview on 06/27/25 at 12:10 P.M., Nurse Aide (NA) #2 said she had been assigned to take care of Resident #87 on the day shifts that week. She confirmed the catheter collection bag did not have a privacy cover. NA #2 said she knew that residents who were up in their wheelchair needed to have a cover over their collection bags but was not sure if residents who stayed in bed, like Resident #87, needed to have one or not. She said she would have to get that clarified so she would know. In an interview on 06/27/24 at 12:57 P.M., the Director of Nursing said catheter collection bags should be covered for both residents in a wheelchair and in bed for resident privacy and dignity.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process,	F 553		7/22/24

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F 553	Continued From page 14 including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, and Power of Attorney interview, the facility failed to invite the resident and/or resident representative to participate in the care planning process for 3 of 32 residents whose care plans were reviewed (Resident #69, Resident #125 and Resident #108). 1. Resident #69 was admitted to the facility on 4/22/24.	F 553	F553 Right to Participate in Planning Care 1a. Resident #69 was admitted to the hospital during the following dates, 7/6/2024 to 7/16/2024. The Readmission care plan conference was completed on 7/19/2024. 1b. Resident #125's Power of Attorney	

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The most recent admission Minimum Data Set (MDS) assessment dated 4/25/24 revealed Resident #69 had been assessed as severely cognitively intact.

Review of Resident #69's care plan revealed it had been reviewed and revised on 5/30/24, but there was no indication that the resident or RP had participated in the care plan meeting.

During a telephone interview on 6/25/24 at 7:52 PM, Resident #69's RP revealed that he was never invited to a care plan meeting.

The Social Services Director (SSD) was interviewed on 6/25/24 at 3:20 PM, and she revealed that she did not work at the facility prior to 5/20/24. She stated that the Assistant Administrator covered the social services duties prior to her arrival.

The Assistant Administrator was interviewed on 6/25/24 at 3:50 PM. She revealed that she was covering social services responsibilities from end of March 2024 until 5/20/24 when the new SSD started at the facility. She stated the initial care plan meeting was usually held via telephone within 72 hours of admission. If family members could not be reached or could not attend, a conference call would be offered. The Assistant Administrator stated that care plan meetings were documented and stored in the facility shared drive. She indicated she could not find Resident #69's care plan meeting documentation after completion of the admission MDS assessment. The Assistant Administrator stated she could not find that the initial care plan meeting was conducted, which was due to human error.

F 553

(POA) was attempted to be reached by the Assistant Administrator to schedule a care plan meeting on 7/16/2024, voicemail left. Care plan invitation mailed to resident's POA, and care plan invitation given to resident on 7/17/2024. Facility is awaiting response from POA to confirm attendance. Care plan meeting is scheduled for the week of 7/29/2024.
1c. Resident #108 no longer resides at the facility.

2abc. All residents have the potential to be affected. An audit of admissions/readmission within the past 30 days (6/17/2024 - 7/17/2024) was completed by Assistant Administrator on 7/17/2024 to verify the completion of The Post Admission Patient/Family Conference. On 7/17/2024, the Assistant Administrator scheduled Care Conferences for Identified Residents.

3abc. Education provided to the Director of Social Services, Social Services Specialist and Assistant Administrator by the Director of Nursing (DON) on facility policy OPS416 Person-Centered Care Plan on 7/17/2024. Education will be provided to all new Nurse Administration hires during their orientation period by DON and/or Designee.

4abc. Director of Nursing (DON) and/or designee will audit all admission/readmissions weekly x4 weeks

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During an interview with the Director of Nursing (DON) on 06/26/24 at 2:59 PM, she revealed that the initial care plan meeting should be held within 72 hours of admission. The previous SSD left 4/24/24 and the Assistant Administrator took over the responsibility of coordinating care plan meetings. The DON stated that Resident #69 and her RP should have been invited to a care plan meeting.

An interview was conducted with the Administrator on 6/26/24 at 3:08 PM, and he revealed Resident #69, and her RP should have been invited to a care plan meeting after the completion of the admission MDS assessment.

2. Resident #125 was admitted to the facility on 2/19/24.

The Minimum Data Set (MDS) quarterly assessment dated 5/27/24 revealed Resident #125 was cognitively intact.

The care plan dated 2/20/24 revealed Resident #125 was admitted for skilled short-term stay and Resident #125 would have an ongoing discharge plan that provided for a safe and effective discharge.

Review of the care plan meeting sign in sheet dated 6/07/24 revealed the Social Service Director and the MDS Nurse #1 conducted Resident #125's care plan meeting. The sign in sheet was noted by the Social Service Director that Resident #125 was not able to come due to care, and Resident #125's Power of Attorney (POA) was called, and message was left. The sign in sheet further reported Resident #125 was

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(starting 7/22/2024), bi-weekly x2 weeks, then monthly x1 month for completion of The Post Admission Patient/Family Conference per facility policy.

Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.

The Director of Nursing will be responsible for the implementation of the plan.

Date of Compliance: 07/22/2024

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communicated later of care plan.

Review of the social service note dated 6/10/24 at 9:40 am by the Social Service Director revealed a care plan meeting was held for Resident #125 in which goals, challenges, and concerns were discussed.

An interview was conducted on 6/24/24 at 11:17 am with Resident #125 who revealed he had not participated in a care plan meeting at the facility. Resident #125 stated he did not get out of bed, and no one had come to his room to have a care plan meeting with him or review his plan of care.

During an interview on 6/25/24 at 3:44 pm with the Social Service Director she revealed Resident #125's care plan meeting was conducted on 6/10/24 and was planned to be held in the conference room but when she went to his room the door was closed and care was being provided so she did not have Resident #125 participate in his care plan meeting. The Social Service Director stated she could have waited and held the meeting with Resident #125 after the care was provided but she did not. She stated Resident #125 should have been present for the care conference meeting.

A telephone interview was conducted on 6/25/24 at 7:12 pm with Resident #125's POA who revealed she did not receive a telephone call or have any telephone messages from the Social Service Director on 6/07/24 or 6/10/24 to participate in Resident #125's care plan meeting.

A follow-up interview was conducted with the Social Service Director on 6/26/24 at 10:10 am who revealed the care plan meeting for Resident

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#125 was held on 6/07/24 not 6/10/24 as previously reported. She stated she called Resident #125's POA twice on 6/07/24 to participate. She stated she was unable to leave a message the first time because it was not set up or something, but she was able to leave a message the second time about the care conference. The Social Service Director stated she was new to the position and still learning and had so many care plan meetings that she could not remember exactly what happened with Resident #125's care conference meeting.

An interview was conducted with the Director of Nursing (DON) on 6/26/24 at 4:07 pm who revealed the care plan meeting schedule was reviewed in the morning team meeting and invitations were placed in resident rooms, so the resident knew when the meeting was. She stated the normal attendees for a care conference meeting would include the Resident, nursing, activities department, social services, and if possible, the nurse aide. The DON stated Resident #125 should have been present at the care conference meeting.

3. Resident # 108 was admitted to the facility on 5/16/2024.

The 5-day admission Minimum Data Set (MDS) assessment dated 5/20/2024 indicated Resident #108 was cognitively intact.

Resident #108's comprehensive care plan was dated completed on 5/20/2024.

There was no documentation in Resident's #108's electronic medical record of an interdisciplinary care plan meeting with Resident #108 or

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Resident #108's Representative after admission to the facility.

On 6/24/2024 at 10:13 am in an interview with Resident #108, she stated she had not been invited to a care plan meeting or attended a care plan meeting since admission to the facility.

On 26/2024 at 3:31 pm in an interview with MDS Nurse #2, she stated interdisciplinary care plan meetings were scheduled and held by the Social Worker Director. She stated the Social Worker Director was new to the position at the time Resident #108 was admitted and was adjusting on learning the process to conduct interdisciplinary care plan meetings.

On 6/25/2024 at 3:44 pm in an interview with the Social Worker Director, she stated she started employment with the facility on 5/20/2024 and was responsible for notifying the resident and/or resident representative to set up the interdisciplinary care plan conference meeting. She explained Resident #108 was admitted to the facility prior to her employment, and the Assistant Administrator was scheduling resident interdisciplinary care plan meetings prior to her employment. The Social Worker Director could not locate documentation that Resident #108 or Resident #108's Representative was notified of an interdisciplinary care plan meeting or that an interdisciplinary care plan meeting had been scheduled for Resident #108. She said there should have been an interdisciplinary care plan conference meeting with Resident #108 and Resident #108 or Resident #108's Representative should have been invited.

On 6/25/2024 at 4:16 pm in an interview with the

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F 553	Continued From page 20 Assistant Administrator, she explained she was scheduling care plan meetings while the facility was seeking employment for a new Social Worker Director. She said she was unable to locate documentation where Resident #108 was invited or that an interdisciplinary care plan meeting was held for Resident #108. She stated Resident #108 should have had an interdisciplinary care meeting and could not provide an answer as to why Resident #108 did not have an care interdisciplinary plan meeting.	F 553		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent	F 576		7/22/24

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with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews the facility failed to provide residents the right to receive mail when delivered on Saturday. This had the potential to affect 127 of 127 residents residing in the facility.

Findings included:

During an interview with Resident #43 on 6/23/24 at 2:30 PM he reported mail was not received in the facility on Saturdays.

An interview with members of the Resident Council on 6/27/24 at 9:34 AM indicated at times they did not receive their mail on Saturday. Residents stated they only got mail on Saturdays if the Activities Director or front office staff were present.

An interview was conducted with the Business Office Manager on 6/27/24 at 11:32 AM who stated the receptionist got the mail and separated it between facility and resident mail. She reported

F 576

F576 Right to Forms of Communication w/ Privacy

1. Business office manager educated on facility policy OPS212 Communication: Patients on 6/27/2024 by the Licensed Nursing Home Administrator (LNHA).

2. All residents have the potential to be affected. Facility initiated a process to record received and delivered incoming resident mail every Saturday. Weekend Reception Staff and/or Designee will record incoming and delivered mail on Saturdays.

3. Education provided to Activity Department staff and Business Office staff by Licensed Nursing Home Administrator (LNHA) on facility policy

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F 576	Continued From page 22 if the mail was for a resident, it would be left at the front desk until Monday when the Activity Director returned to work. The Business Office Manager stated if the mail appeared to be a birthday card or something similar the receptionist took it to the resident but otherwise the mail waited until Monday. The Activities Director was unavailable for interview. During an interview with the Administrator on 6/27/24 at 1:14PM he stated the weekend receptionist should be delivering resident mail on Saturday. He stated the Activities Director was present every other weekend, but the weekend receptionist was responsible for delivering the mail.	F 576	OPS212 Communication: Patients on 6/27/2024. Education will be provided to all new Activity and Administrative Support hires during their orientation period by LNHA and/or Designee. 4. Licensed Nursing Home Administrator (LNHA) and/or designee will audit facility record of incoming mail every Saturday weekly x12 weeks (starting 7/22/2024) for adherence to facility policy OPS212 Communication: Patients. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Licensed Nursing Home Administrator will be responsible for the implementation of the plan. Date of Compliance: 07/22/2024	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		7/21/24

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F 658	Continued From page 23 Based on record review, observations and staff interviews, the facility failed to discontinue the use of a wander guard for a resident based on a physician's order and the elopement assessment on 1/30/2024. The resident was observed with a wander guard on the left ankle with no physician's order for the use of a wander guard for elopement prevention and no documentation of the monitoring of the use of the wander guard for 1 of 7 residents reviewed for accidents (Resident #120). Findings included: Resident #120 was admitted to the facility on 10/23/2023. Diagnoses included hypertension and heart failure. The physician order written on 10/24/2024 read to check placement and location every shift of a wander guard/wander elopement device used due to poor safety awareness. Resident #120's care plan dated 10/24/23 indicated Resident #120 was a risk for elopement. Interventions included monitoring Resident #120's location, conducting regular frequent visual checks and utilizing and monitoring the wander guard device. Resident #120 was discharged from the facility to the hospital on 12/18/2023. A physician order to discontinue the wander guard was written on 12/20/2023. Resident #120 was re-admitted to the facility on 12/27/2023.	F 658	F658 Services Provided to Meet Professional Standards 1. On 6/26/2024, Unit Manager #1 completed an Elopement Assessment on Resident #120. Unit Manager #1 found that Resident #120 was not at risk for elopement and removed the wander guard. 2. All residents have the potential to be affected. A facility wide audit was completed to ensure that no residents had a wander guard in place without a physician order and a current assessment indicating resident at risk for elopement by designee on 7/18/2024. Audit was without any negative findings. An audit was completed on current residents with a wander guard order in place on 7/18/2024 by designee to ensure that wander guards were in place as prescribed and that physician wander guard orders were complete with placement location listed for monitoring and included a wander guard function check per facility policy. Corrections made as needed by designee on 7/18/2024. Orders were then reviewed by DON for accuracy on 7/18/2024. An audit was completed by the Director of Nursing (DON) on 7/17/2024 to ensure that all current residents had an accurate and timely elopement assessment present per facility policy. Residents that flagged during the audit had an Elopement	

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An elopement evaluation dated 1/30/2024 was conducted by Nurse #1. All answers on the elopement assessment were marked as "no" and indicated Resident #120 was not an elopement risk.

The quarterly Minimum Data Set (MDS) assessment dated 4/2/2024 indicated Resident #120 was severely cognitively impaired with no behaviors recorded. The use of a wander guard was not marked on the MDS assessment.

There was no nursing documentation in Resident #120's electronic medical record (EMR) reporting behaviors of elopement for Resident #120 since admission to the facility.

There was physician documentation in Resident #120's EMR reporting behaviors of elopement for Resident #120 since admission to the facility.

A review of the physician's orders for Resident #120 indicated no current physician order for the use of a wander guard.

There was no nursing documentation of monitoring the location of Resident #120's wander guard device on his June 2024 Treatment Administration Record.

On 6/24/2024 at 11:03 am, Resident #120 was observed using a walker in the hallway walking from the facility's designated smoking area toward his room with a wander guard on his left ankle.

On 6/26/2024 at 2:40 pm in an interview with Resident #120, he raised his left pant leg and stated the device (wander guard) on his leg ankle

F 658

Assessment completed by designee on 7/18/2024. Assessments were then reviewed by DON for accuracy on 7/18/2024.

3. Education provided to all licensed nurse staff to include FT, PT, PRN and agency staff on facility policies OPS111 Elopement of Patient and NSG121 Patient security Bracelet. Education completed by Nurse Practice Educator (NPE) and/or designee by 07/21/2024. Education will be provided to all new licensed nurse staff to include FT, PT, PRN and agency staff hires during their orientation period by NPE and/or Designee.

4. The Director of Nursing (DON) and/or designee will audit daily x2 weeks (starting 7/22/2024), weekly x2 weeks, bi-weekly x2 weeks, then monthly x1 month to ensure no resident has a wander guard in place without necessity, by verifying residents with a wander guard in place have an active physician order and an Elopement assessment indicating a risk for elopement. Confirming that Elopement assessments are completed accurately and timely per facility policy.

Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure

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F 658	Continued From page 25 had been there since before his admission to the hospital (12/18/23). Resident #120 was not able to explain why the wander guard was on his left ankle. He said the wander guard device bothered him being there. On 6/27/2024 at 10:14 am in an interview with Nurse #1, she stated she did not know why Resident #120 was wearing a wander guard. She explained Resident #120 walked the hallways at night when he was unable to sleep, and she had not observed Resident #120 trying to exit the facility or entering other residents' rooms. She further stated all doors exiting the facility were locked at the facility. On 6/26/2024 at 2:45 pm in an interview with Unit Manager #2, she stated Resident #120 was wearing a wander guard because Resident #120 was disoriented at times and wandered around in the facility. Unit Manager #2 was unable to recall any incidents of Resident #120 trying to elope from the facility. She said she was not aware there was not a physician order for Resident #120's wander guard and explained nursing was to monitor placement of the wander guard when in use. On 6/26/2024 at 4:30 pm in an interview with the Receptionist, she stated the front entrance doors were always locked. She explained when Resident #120 was near the front entrance door with the wander guard on, she was unable to unlock the front door from the Receptionist's desk and an alarm would activate when Resident #120 was near the unlocked or open front door entrance door that required someone to deactivate the alarm at the keypad near the front entrance door. The Receptionist recalled no	F 658	the facility remains in compliance. The Director of Nursing will be responsible for the implementation of the plan. Date of Compliance: 07/21/2024	

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F 658	Continued From page 26 incidents of Resident #120 attempting to exit the facility. On 6/26/2024 at 5:00 pm in an interview with the Director of Nursing, she stated she was not aware that Resident #120 had a wander guard device on his left ankle. She explained the use of a wander guard for Resident #120 was based on how the questions were answered on the elopement evaluation and behaviors exhibited and any score greater than zero indicated the resident was at risk for elopement. She said Resident #120 should have been reassessed for an elopement risk when readmitted to the facility and every three months afterwards. She stated nursing staff should have obtained a physician order for the use of the wander guard and monitored placement of the wander guard.	F 658		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		7/18/24

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

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

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to post nurse staffing information at the beginning of each shift for 2 of 4 days during the survey and failed to post nurse staffing information for 47 of 57 days reviewed from 5/1/24 through 6/26/24.

The findings included:

1. An observation conducted on 6/26/24 at 2:04 PM revealed nurse staffing information posted in the lobby was dated 6/24/24.

The Director of Nursing (DON) was interviewed on 6/26/24 at 2:08 PM. She revealed that she and the Administrator were responsible for posting nurse staffing information at that time because the new scheduler was still in training after being

F 732

F732 Posted Nurse Staffing Information

1. Nurse staffing information completed and posted on 6/26/24.

2. All residents have the potential to be affected. Audit completed of the past 14 days to review all past staff postings for completion and/or accuracy per facility policy and/or CMS regulation. Audit completed by Director of Nursing (DON) on 7/17/2024, no deficiencies noted.

3. Education provided to Licensed Nursing Home Administrator (LNHA) and

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F 732	Continued From page 28 hired on 6/21/24. She indicated that the staff posting for 6/25/24 was completed but not displayed, and she forgot to do the staff posting for 6/26/24. An interview was conducted with the Administrator on 6/27/24 at 11:45 AM, and he stated nurse staffing information should be accurate and posted daily. 2. A review of the posted nurse staffing information sheets from 5/1/24 through 6/26/24 revealed that there was not any documentation of staff postings from 5/1/24 - 6/16/24. The DON was interviewed on 6/27/24 at 11:40 AM, and she revealed that within the last 2 months, she only had staff postings for 6/17/24 - 6/26/24. She stated during the month of May 2024, she was assisting another building and did not know the staff postings were not being completed. She stated they hired a new scheduler, and the responsibilities of staff postings were split between the DON and the Administrator. The Administrator was interviewed on 6/27/24 at 11:45 AM. He revealed the scheduler at that time did not complete the task of staff postings consistently, and the DON was trying to keep them current. However, the staff postings should be completed in a timely manner.	F 732	Director of Nursing (DON) on Company policy OPS130 Posting Staffing, by Regional Nurse Consultant on 6/26/2024. Education provided to facility scheduler on facility policy OPS130 Posting Staffing, by DON on 6/26/2024. Education will be provided to all new Nurse Administration hires during their orientation period by DON and/or Designee. 4. The Director of Nursing (DON) and/or designee will audit facility posted nurse staffing information for completion, display, and accuracy per facility policy daily for 2 weeks to begin 07/18/2024, weekly x2 weeks, 5 random days bi-weekly x2 weeks, 10 random days monthly x1 month. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Director of Nursing will be responsible for the implementation of this plan. Date of Compliance: 07/18/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		7/21/24

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F 812	Continued From page 29 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to allow cooking pans and dome lids to completely dry prior to assemblage and stacking for two of two observations. These practices had the potential to affect food served to residents. The findings included: An observation of the kitchen and interview with the Registered Dietitian (RD) was conducted on 6/24/24 at 9:57 AM. Thirty-three meal trays were observed to be stacked wet and ready for reuse on a cart next to the tray line. The RD stated the meal trays should be air dried before meal service. She then instructed kitchen staff to rewash, and air dry the trays that were stacked wet.	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. Drying rack was immediately placed in the kitchen on 6/24/2024 by the Dietary Director of Operations. Items that were noted not properly air-dried were immediately removed from circulation, rewashed and stored properly by Dietary Staff as instructed on 6/24/2024 by the Dietary Director of Operations. 2. All residents have the potential to be affected. Audit established to ensure kitchen smallware are properly air dried and stored after disinfection and/or washing per HCSG policy 022	

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F 812	Continued From page 30 An observation of the kitchen and interview with the RD was conducted on 6/24/24 at 10:16 AM and revealed twenty dinner plates were stacked wet ready for reuse next to the tray line. The RD stated the plates should have been air dried. The Administrator was interviewed on 6/26/24 at 3:15 PM. He stated that kitchen staff should have air dried the meal trays and dinner plates.	F 812	Warewashing and policy 023 Manual Warewashing. 3. Education initiated with Dietary Staff on 6/24/2024 by the Registered Dietician (RD) on HealthCare Services Group (HCSG) policy 022 Warewashing and policy 023 Manual Warewashing. Education to be completed by 7/21/2024. Education will be provided to all new dietary hires during their orientation period by the Dietary Manager and/or Designee. 4. Registered Dietician (RD) and/or designee will audit all 3 meals daily x2 weeks (starting 7/22/2024), 7 random meals weekly x2 weeks, 7 random meals bi-weekly x2 weeks, then 10 random meals monthly x1 month to ensure smallware are properly air dried and stored per HCSG policy 022 Warewashing and policy 023 Manual Warewashing. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Licensed Nursing Home Administrator will be responsible for the implementation of this plan. Date of Compliance: 07/21/2024	

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F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and Nurse Pracitioner and staff interviews, the facility failed to provide speech therapy services as ordered for 1 of 1 resident reviewed for therapy services (Resident #287). The findings included: The hospital Speech Therapy Swallow Assessment dated 8/20/23 revealed Resident #287 was determined to be a moderate risk for aspiration and was recommended for a puree diet with moderately thick liquids. Resident #287 was admitted to the facility on	F 825	F825 Provide/Obtain Specialized Rehab Services 1. Resident #287 no longer resides at the facility. Full Time (FT) Speech-Language Pathology (SLP) began at the facility on 12/11/2023. 2. All residents have the potential to be affected. An audit was completed by the Assistant Administrator on 7/19/2024 of admission/readmissions for the past 30 days to ensure that Speech Therapy	7/22/24

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F 825	Continued From page 32 8/26/23 with diagnosis which included stroke with left side hemiplegia (paralysis) and dysarthria (weakened or paralyzed muscles which make it difficult to control tongue or voice box). A physician order dated 8/26/23 for speech therapy evaluation and treatment as recommended. A physician order dated 8/26/23 for puree diet with honey thick liquids. The care plan dated 8/28/23 revealed Resident #287 required assistance for eating with an intervention for speech therapy treatment as ordered by the physician. The Minimum Data Set (MDS) discharge return not anticipated assessment dated 9/13/23 revealed Resident #287 was cognitively intact and required supervision with eating. Resident #287 was not coded for speech therapy minutes. An interview was conducted on 6/25/24 at 12: 54 pm with the Rehabilitation Director who revealed the normal process for a newly admitted resident with diagnosis of stroke and on a puree diet would include a speech therapy screen or evaluation and that would determine the speech therapy plan of care including how many days of therapy and goals. She stated speech therapy services were used for cognition, swallowing needs, and diet upgrades. The Rehabilitation Director stated Resident #287 had a speech therapy screen completed on 8/28/23 and it was determined that Resident #287 was not a candidate for speech therapy services. During a follow-up interview on 6/25/24 at 2:06	F 825	screened and/or evaluated residents per indication and/or recommendation. Residents identified to be without speech screen and/or evaluation per indication and/or recommendation will be reviewed by Nurse Practitioner and/or designee by 7/22/2024. 3. Education provided to facility Director of Rehab (DOR) on facility policy OPS405 Interdisciplinary Therapy Screen by Director of Nursing (DON) on 7/15/2024. 4. Director of Nursing (DON) and/or designee will audit all admission/readmission daily x2 weeks (starting 7/22/2024), weekly x2 weeks, bi-weekly x2 weeks, then monthly x1 month to ensure that Speech Therapy screened and/or evaluated residents per indication and/or recommendation. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Director of Nursing will be responsible for the implementation of the plan. Date of Compliance: 07/22/2024	

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F 825	Continued From page 33 pm with the Rehabilitation Director she revealed she was unable to locate documentation that Resident #287 had been provided a speech therapy screen while at the facility. The Rehabilitation Director stated she previously reported that Resident #287 had the speech therapy screen completed on 8/28/23 because it looked like it had been completed in the medical record, but she confirmed Resident #287 did not received any speech therapy services. The Rehabilitation Director stated the facility went several months without a speech therapist, but she was unable to recall if that was at the time Resident #287 was at the facility. She stated the facility did have a per diem (as needed) speech therapist that would come occasionally, and she completed speech therapy evaluations during that time. The Rehabilitation Director stated she was also out of work for several weeks on medical leave at the same time the facility was without a speech therapist so that may have been when Resident #287 was at the facility, but she was unable to state for certain why Resident #287 did not receive speech therapy services while at the facility. An interview was conducted with the Director of Nursing (DON) on 6/26/24 at 3:55 pm who revealed she was not aware Resident #287 was not seen by speech therapy at the facility. A telephone interview was conducted on 6/27/24 at 9:47 am with the Nurse Practitioner (NP) who revealed she did not recall Resident #287, but she believed she was aware that the facility was without a speech therapist for a time. The NP stated she was unable to recall if she was notified that speech therapy services were not provided for Resident #287.	F 825		

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F 825	Continued From page 34 An interview was conducted on 6/27/24 at 9:51am with the Administrator who revealed he was aware that for a brief period the facility did not have a speech therapist in the building, but he stated the Rehabiliation Director was helping with the speech therapy needs. The Administrator stated he did not recall Resident #287 so he would have to speak to the Rehabilitation Director to state why the speech therapy services were not provided.	F 825		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review, the facility failed to maintain an effective pest control program as evidenced by observations of fly activity in the kitchen, in resident rooms (Resident #113, Resident #24, and Resident #102), and on the 100 and 300 halls. Additionally, the facility failed to utilize insect light traps (installed to trap flies) and implement recommendations made by the pest control service provider to prevent reoccurring pest activity in the kitchen area. This deficient practice had the potential to affect residents in the facility. The findings included: 1. Review of the Pest Control Terms and Conditions contract dated 4/4/24 revealed common small and large flies were covered by	F 925	F925 Maintains Effective Pest Control Program 1. A compact portable plugin ultrasonic fly repellent was placed in Residents #113 and #24 rooms by the Maintenance Director on 7/19/2024. A compact portable plugin ultrasonic fly repellent was placed throughout 100 and 300 Halls by the Maintenance Director on 7/19/2024. A fly trapping machine was placed at the Nurse stations located on 100, 200 and 300 Halls by the Maintenance Director on 7/19/2024. On 6/26/2024 the Maintenance Director inspected both already in place electrical outlets in the Kitchen, used to power fly trapping machines. Upon evaluation, Maintenance Director found	7/19/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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the contract.

Review of service maintenance invoices from 5/7/24 through 6/22/24 revealed that new recommendations for the kitchen/cafeteria area were made by the pest control company on 5/7/24. These recommendations included: repair cracks or damage to wall to prevent pest access, repair cracks or damage to floor to prevent pest entry, fill in gaps where pipes extend through wall to prevent pest entry, and remove accumulation of food product from damaged goods to prevent attraction by pests. No fly activity was noted.

An observation of the kitchen and interviews with the Registered Dietitian (RD) and Dietary Manager (DM) was conducted on 6/24/24 at 10:00 AM. There were 2 flies seen flying around the area of the tray line. The RD stated that those flies were not present prior to that moment. The DM stated there were 2 fly trapping machines in the cook's area located at the back of the kitchen on either wall installed by maintenance recently, but they were not turned on yet.

An observation of the dry storage area and interview with the DM took place on 6/24/24 at 10:10 AM. There were 3 fruit flies seen in the area, and a cereal bag was left open to air. The DM stated the cereal bag was not used, and staff only opened the end of the bag. However, it should have been wrapped properly. The DM stated that bananas used to be kept in dry storage, which caused the fruit flies to appear, but now the bananas were kept in the kitchen area.

Review of work orders by the Maintenance Director for pest control recommendations dated

F 925 (Plan of Correction)

the breaker in the Kitchen's fuse box, that powered outlets was flipped to the neutral position. This prevented electricity flow to both outlets. The Maintenance Director flipped the breaker to the on position, to allow electricity to flow into both outlets, enabling both fly trapping machines to function properly; relocation of the two fly trapping machines was not necessary.

2. All residents have the potential to be affected. The Maintenance Director signed an agreement with the current pest control company on 7/5/2024 to increase frequency of fly treatment to weekly for 8 weeks (starting the week of 7/8/2024). The Maintenance Director will enter into TELS the recommendations made by the pest control company and complete the work orders timely.

3. Education provided to the Maintenance Director and Maintenance Assistant on Policy FNS408 Pest Control and Policy PM105 Infection Control Practices by the Licensed Nursing Home Administrator (LNHA) on 7/4/2024.

4. The LNHA and/or designee will audit Pest control recommendations to ensure recommendations have been entered into TELS timely and verify completion of TELS work orders weekly x8 weeks, then monthly for x1 month.

Results of these audits will be brought

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6/24/24 revealed the work was initiated at 12:02 PM and were resolved by 4:50 PM the same day.

An observation and interviews with the Director of Operations and DM was conducted on 6/26/24 at 11:47 AM. A fly was observed to land on the ice machine. The Director of Operations confirmed the fly presence. The fly trapping machines in the back of the kitchen on either wall were not turned on. The DM stated she was not sure why they were not turned on yet, and maintenance was responsible for the fly trapping machines. It was observed that there was not a lid on top of the trash receptacle located in the dish area. The Director of Operations retrieved the lid and stated she had to sanitize it first.

On 6/26/24 at 10:02 AM, the Maintenance Director was interviewed. When he first started at the facility, the previous pest control company was replaced with the current one because they were not compliant with the contract. There was one fly trapping machine that was installed by the previous pest control company, so he replaced that with 2 new ones in the back of the kitchen. No staff in the kitchen had complained to him about flies in the kitchen. He indicated that one of the problems he noticed was that kitchen staff left the back door open at times. The Maintenance Director stated he installed a new fly curtain at the kitchen back door about 5 months ago because the curtain was blowing in the wrong direction; however, the staff continued to leave the back door open. The Maintenance Director indicated that he has educated kitchen staff numerous times to keep the door closed. He stated he had implemented most recommendations from the pest control company, but he did not observe any holes/cracks in the walls. However, the areas

F 925

before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.

The Licensed Nursing Home Administrator will be responsible for the implementation of this plan.

Date of Compliance: 07/19/2024

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were sealed around the pipes in the walls anyway. The Maintenance Director stated he did not know that the recommendations were included in the invoices because they were supposed to be emailed to him. He was emailed documents by the pest control company, but the display was coding and not words. He stated he had not yet contacted the company about the documentation issue.

During an interview with the Administrator on 6/26/24 at 3:12 PM, he revealed that the fly trapping machines in the kitchen needed to be relocated because an outlet was not located close enough to turn them on. He stated the pest program was effective because the pest presence had improved within the last 2 months. The Administrator indicated that a pest control program was considered effective if there was continuous improvement.

2a. Resident #113 was admitted to the facility on 11/28/23.

The Minimum Data Set (MDS) quarterly assessment dated 5/13/24 revealed Resident #113 was cognitively intact.

During an observation and interview on 6/25/24 at 12:55 pm Resident #113 was observed to be sitting in her wheelchair eating lunch with a fly swatter on her bed next to her meal tray. Multiple flies were observed in the room. Resident #113 stated she had to kill flies all the time in her room.

b. Resident #24 was admitted to the facility on 7/13/11.

The Minimum Data Set (MDS) quarterly

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F 925	Continued From page 38 assessment dated 4/15/24 revealed Resident #24 was cognitively intact. An observation and interview were conducted on 6/25/24 at 1:08 pm with Resident #24. Resident #24 was observed sitting in bed with the finished meal tray on the bedside table and a fly swatter on the bed. Multiple flies were observed in the room. Resident #24 stated the flies were bad so he keeps a fly swatter with him so he can kill the flies in his room. c. During an observation of medication administration on 6/26/24 at 8:21 am on Hall 100 flies were observed to be flying around the open container of pudding and the water pitcher located on the top of the medication cart while Nurse #4 prepared to administer medications. An observation of medication administration was conducted on 6/26/24 at 8:43 am with Nurse #4 on Hall 100. Nurse #4 entered the room to administer medications to Resident #102 and multiple flies were observed to be flying around the Resident #102's head, uneaten breakfast meal tray, and Nurse #4's head. Nurse #4 was observed to use her hand to swat at the flies around the meal tray. An interview was conducted with Nurse #4 on 6/26/24 at 8:47 am who revealed she had only been working at the facility for a few weeks but stated the flies have been bad since she started working. Nurse #4 reported she was not sure if it was normal for this time of year to have this many flies because they were so bad. d. During an observation and of medication administration on 6/26/24 at 9:08 am on Hall 300	F 925		

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multiple flies were observed flying around the medication cart and Nurse #6 while she prepared to administer medications. Nurse #6 was observed to swat her hand at flies during the observation.

An interview was conducted on 6/26/24 at 9:12 am with Nurse #6 who revealed the flies were bad in the facility. She stated the facility put up blue lights (fly attraction lights) in the hall about one week ago, but she stated she did not see any improvement yet with the number of flies in the facility.

During an interview on 6/27/24 at 8:30 am the Maintenance Director revealed he installed blue lights in the halls last week and felt the lights have helped with the fly problem. He stated he had previously placed small blue lights in resident rooms but when the new pest control company started recently they recommended removal of the blue lights from resident rooms to attract the flies outside of the rooms. He stated the facility had air curtains (machine hung above the entrance/exit doors which blows a controlled stream of air when the door opened to keep pests like flies from entering the building) at the exit and entrance doors but he stated that the main lobby doors had worn out gaskets which he replaced during the past week so the flies may have entered through the main door entrance. The Maintenance Director stated he had not received any complaints recently about flies in resident rooms.

An interview was conducted with the Administrator who revealed the previous pest control company had removed the blue lights from the facility when the new company was

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F 925	Continued From page 40 hired. The Administrator stated he believed the Maintenance Director was working on the recommendations the new pest control company had given.	F 925		