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F 000	INITIAL COMMENTS A complaint investigation was conducted on 07/15/24 through 07/17/24. Additional information was obtained remotely on 07/19/24. Therefore, the exit date was 07/19/24. Event ID #LMC211. The following intakes were investigated: NC00217858 and NC00219238. Intake NC00219238 resulted in immediate jeopardy. 1 of the 3 complaint allegations resulted in deficiency. Past Non-Compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The Tag F689 constituted Substandard Quality of Care. Immediate jeopardy for F689 began on 7/5/24, the immediate jeopardy was removed on 7/6/24, and the tag was corrected on 7/12/24. A partial extended survey was conducted.	F 000		
F 689 SS=J	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.	F 689		

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

Electronically Signed | 08/07/2024

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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, staff, and Nurse Practitioner interviews, the facility failed to prevent Resident #1 from being left unsupervised in the facility ' s transportation van when Transporter #1 left the resident in the van with the doors and windows closed and the engine turned off midday in the summer heat (07/05/24) for approximately 10 to 30 minutes. The temperature outside was between 92 and 94 degrees Fahrenheit (F). The facility staff did not identify Resident #1 was not in the facility until his family member arrived at the facility and was unable to locate him. Resident #1 indicated he was yelling for help, he was panicked, became short of breath, was scared, and thought he was going die. Resident #1 did not sustain any physical injures, but there was a high likelihood of suffering serious harm that included heat stroke (a medical emergency that can result in permanent disability or death). This deficient practice affected 1 of 4 residents reviewed for transport in the facility van. Findings included: Resident #1 was most recently admitted to the facility on 06/15/24 with a diagnosis of dementia, right hip fracture, and muscle weakness. Review of a Minimum Data Set 5 day assessment dated 06/21/24 revealed Resident #1 had intact cognition. He had an impairment on one side of the lower extremity. He required substantial assistance for all activities of daily living. He had recent orthopedic surgery that required skilled nursing facility care.	F 689	Past noncompliance: no plan of correction required.	

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Review of the care plan for Resident #1 dated 05/23/24 identified initial care needs, risks, strengths, and goals. The goal was for Resident #1 to have access to necessary services to promote adjustment to his new living environment and/or post discharge from facility. Approaches included, in part: Minimize potential risk factors related to falls or injury and receive necessary assistance for activities of daily living; transfer and ambulate with rolling walker with one assist.

An interview was conducted on 07/15/24 at 10:20 AM with the family member who accompanied Resident #1 to his doctor ' s appointment on 07/05/24. She stated at 10:30 AM on 07/05/24 she called Transporter #1 and told her Resident #1 was ready to be picked up at the doctor ' s office and brought back to the facility. She recalled approximately 15 minutes later, Transporter #1 picked Resident #1 up in the facility van and she (Resident #1 ' s family member) left to run errands before returning to the facility. She stated she arrived back at the facility around 11:30 AM and started looking for Resident #1. She could not find him. She was going to leave his lunch with the nurse and leave when she noticed the Business Office Manager, who had been in the van during transport, was in her office. She asked the Business Office Manager where Resident #1 was, and the Business Office Manager did not know. Resident #1 ' s family member asked Nurse #1 where Resident #1 was, and the nurse replied she thought he was at a doctor ' s appointment. The family member called Transporter #1 at 12:11 PM to find out the whereabouts of Resident #1. She stated Transporter #1 told her Resident #1 was in the building somewhere. Resident #1 ' s family member indicated she and the Business Office

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Manager continued to look for the resident inside and outside. Then the Business Office Manager told her Transporter #1 found Resident #1 outside in the facility van. The family member watched Transporter #1 wheel him into his room. The family member stated Transporter #1 apologized and explained that there had been no place to park the van in the front of the building, so she parked the van in the back and had left Resident #1 in the van.

A software application for navigation revealed the location of the doctor ' s office where Resident #1 had an appointment was 2.2 miles away from the facility and would take 7 minutes to drive to or from taking the fastest route.

An interview was conducted with Resident #1 on 07/15/24 at 10:50 AM. Resident #1 stated if his family member had not looked for him when he was left alone on the van on 07/05/24 he "would have died." He explained he had been transported by the facility to a doctor ' s appointment on 07/05/24 and when Transporter #1, the Business Office Manager, and he returned, Transporter #1 got out of the van and left him in the van alone locked in his wheelchair. He recalled he couldn ' t move his feet and couldn ' t get up. He was secured into the wheelchair in the van. No windows had been left open, but he was beside a window, and he was able to open it with his finger about a quarter of an inch. It was the emergency window beside his wheelchair, and it had to be held open, it did not stay open by itself. He stated he was yelling for help, but no one heard him. He reported the transportation van was parked in the sun, and it was hot. He thought he had been left there for about an hour. He stated as time went on, he

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"panicked, became short of breath, and became more scared." He recalled a man walked past the van, but he couldn ' t get his attention. He was locked in and could not get out of the van. He stated he was scared he was going to die because it was hot as the "devil", and he didn ' t think he was going to "last very long." After Transporter #1 found him, she took him into the building, put him by the air conditioning unit in his room and gave him water. He reported he was very hot, short of breath, and sweaty. He stated he would not get back in the van with Transporter #1 or the Business Office Manager again. He never wanted to experience that again because "it felt like the end of the world." He concluded he was sure if his family member had not been looking for him, he "would have died in the van that day."

On 07/15/24 review of the Weather by CustomWeather website revealed the outdoor air temperature in the town where the facility was located on 07/05/24 at 11:53 AM was 92 degrees Fahrenheit (F), 94 degrees F at 12:53 PM, and sunny.

The Centers for Disease Control and Prevention ' s (CDC) "Beat the Heat: Extreme Heat" informational document indicated during extreme heat the temperature in a vehicle can be deadly. With an outside temperature of 80 degrees F the temperature inside a car rises to 109 degrees F in 20 minutes and 118 degrees F in 40 minutes.

An interview was conducted with Transporter #1 on 07/15/24 at 12:33 PM. She stated she had been employed at the facility for six years and had been the transporter for two years. She was trained to transport by the previous transporter

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who retired. She stated she transported Resident #1 to a doctor ' s appointment on 07/05/24. The Business Office Manager was with her because Transporter #1 couldn ' t push the resident ' s wheelchair due to a previous shoulder injury. The Business Office Manager had assisted by wheeling Resident #1 onto the van. Transporter #1 strapped him in behind the driver seat in the first wheelchair space that was located toward the back behind 3 stationary rows of seats. Resident #1 was the only resident on the van. She explained when they arrived at the facility after the resident ' s appointment, cars were parked in the driveway, and she could not pull in to get the resident off the van. She explained this was the location they normally parked to offload the residents from the van. She stated she was frustrated after she waited about 2 or 3 minutes, and she told the Business Office Manager to go back to work. She stated she tried to maneuver the van around the parked cars under the awning to offload Resident #1 in the front, and when she could not, she became frustrated, and drove to the back of the building to the space where the van was stored. After she backed the van into the designated unshaded parking space beside the Maintenance Building, she heard her phone beep. The engine was still running when her phone beeped with a message from a doctor ' s office about a different appointment for a resident that she was unaware of. Transporter #1 explained she became agitated because she knew she had not made a scheduling mistake and missed taking a different resident to an appointment. Transporter #1 stated she shut the van off and went into the building forgetting that Resident #1 was still in the van. After she went back into the building and was in her office, she began scheduling appointments for other

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residents and worked for about 10 to 15 minutes. She indicated at that time, a family member of Resident #1 called her on the transporter phone and asked her where Resident #1 was because she could not find him. She told the family member Resident #1 was in the building and she continued working for "no more than 20 minutes." Transporter #1 recalled when she left her office she met up with the Activities Assistant in the hallway and thought, "Oh, sh**!" because she realized she had left Resident #1 in the van. Transporter #1 went out to the van and Resident #1 was in the van. She stated she asked Resident #1 if he was alright and he replied, "it was a little warm." She observed he had removed the anchoring hooks in the front of the wheelchair but was still strapped in behind his chair. She had not noticed he had unlatched the emergency window to the left of his chair until she drove off and the window slammed shut. She did not know if the window had been open because it did not slide or prop open but had to be held when open. She reported she was scared because she thought he had tried to remove his seatbelt "like he was trying to get out of the van himself." She moved the van to the loading dock area in the back of the building to get him off the van. Transporter #1 commented she had parked the van in the storage area originally because she was frustrated, agitated, and wasn ' t thinking. She estimated Resident #1 could not have been left in the van alone for more than 20 minutes. She explained that once she got him into the building, she stopped in the service hall and called for the aide to get the nurse. She was told by Nurse Aide #1 that Nurse #1 and the family member were together looking for Resident #1. She took the resident to his room, put him by the air conditioner and gave him a cup of water.

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When the family member came to the room, Transporter #1 explained to the family member that she had left the resident in the van alone. She went to tell Nurse #1 what had happened, she looked busy, so she went and told the Nurse Practitioner that she had left Resident #1 on the van and asked her to assess. She verified this was after she had placed him in front of the air conditioner and had given him ice water to drink.

In an additional interview with Transporter #1 on 07/19/24 at 2:35 PM via the telephone, she stated that after she returned to her workstation and reviewed her transportation schedule, she had responded to the text from the doctor ' s office at 12:01 PM on 07/05/24. She indicated she was unable to tell what time she originally heard the phone beep with the receipt of the message. She explained the original text came to her at 10:30 AM but she didn ' t know it until it beeped again to remind her to check her texts. She stated she only knew she responded to it at 12:01 PM. She said when she went back into the building the first thing she did was check the schedule and responded to the text. At that time, she was in her office working and had not yet realized she had left Resident #1 in the van. Transporter #1 did not know what time it was when she realized Resident #1 had been left in the van alone.

The storage parking space for the facility van was observed on 07/15/24 at 11:50 AM. The parking space was located to the back of the facility along the side in the last space next to the maintenance building and in front of the tree line. There was no awing or shade in the parking space. There were 2 orange cones on the white parking lot lines that designated the space for storage of the

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facility van.

An observation of the facility van was made on 07/15/24 at 11:45 AM in the presence of Transporter #1 and the Business Office Manager. Transporter #1 illustrated where Resident #1 was locked in the van on 07/05/24. The area where Resident #1 was seated was the first wheelchair space behind the driver and three rows of stationary seats (for ambulatory residents). Transporter #1 demonstrated how the resident ' s wheelchair was secured into position with two hooks in the front that hooked into the floor and two hooks on the back that hooked into the floor. The seat belt was applied from back to front around the occupant and hooked in the back. Transporter #1 explained a resident secured in the wheelchair would not be able to unhook the attachments in back of the wheelchair. There was an emergency window located to the left of the location where the resident was positioned that was within reach of Resident #1 on 07/05/24. The window had to be unlatched on each side and would open with pressure but would not remain open unless held.

An interview was conducted with the Business Office Manager on 07/15/24 at 11:19 AM. She stated she had ridden along with Transporter #1 to take Resident #1 to his doctor ' s appointment on 07/05/24 because Transporter #1 was on restrictions for a recent shoulder injury and was not supposed to push his wheelchair. She stated it was around 11:00 AM when they picked up Resident #1 from his doctor ' s appointment. The Business Office Manager pushed him out of the doctor ' s office and loaded him onto the van then Transporter #1 strapped him in because she did not know how to strap the wheelchair. When they

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arrived back at the building there were 2 cars in the driveway preventing them from parking the van under the awning. They waited for about 10 minutes for the vehicles to move but it turned out they were visitors, and they did not move. The Business Office Manager stated that Transporter #1 told her to go ahead and go back to work, and Transporter #1 would wait for the cars to move and offload the resident herself. She stated she was not sure how much time had passed before Transporter #1 decided to move the van to the storage space in back of the building because she had returned to her office inside the building. The last time she saw Resident #1 was when she and Transporter #1 had been waiting for the cars to move. Around 11:30 AM Resident #1 ' s family member came to her door and stated, "Oh, you ' re back!" The family member told her she was looking for the resident. The Business Office Manager advised the family member to check the therapy room to find him. Nurse Aide #1 who had been looking for Resident #1 came to her and told her Resident #1 was not in the building and could not be found. She tried to call Transporter #1 on the transportation phone, but she didn ' t pick up. She got up and told the Activities Assistant to go find Transporter #1 and then she went out the front door, went down the sidewalk and saw the van parked on the side of the building. She turned around and went back into the building. The Business Office Manager stated she had sent the Activities Assistant to find Transporter #1 to determine where Transporter #1 had put the resident and that ' s when Transporter #1 realized she had left him in the van. The Activities Assistant came back to her and reported Transporter #1 had left the Resident #1 on the van. By the time she got back to the back of the building Transporter #1 had taken the

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resident out of the van and was wheeling him up the sidewalk. She told Transporter #1 to make sure she gave the Resident #1 water. The Business Office Manager recalled Transporter #1 took Resident #1 to his room, gave him ice water, told Nurse #1, and went to the front of the building to get the Nurse Practitioner. The Business Office Manager reported the Nurse Practitioner went immediately to assess the resident.

An interview was conducted with the Activities Assistant on 07/16/24 a 3:49 PM. She stated Resident #1 ' s family member and a nurse aide came to the Activities Department looking for Resident #1 on 07/05/24 around lunchtime. The Activities Assistant saw Transporter #1 coming down the hall and she reported she asked the transporter if she had seen Resident #1 and she replied, "He ' s here in the building." She explained she asked Transporter #1, "Did you leave him on the van?" Transporter #1 told her she would go and check the van. She concluded that she went and found the Business Office Manager, and she and the Business Office Manager went outside together.

An interview was conducted with Nurse Aide #1 on 07/16/24 at 12:04 PM. She stated she cared for Resident #1 on 07/05/24 on day shift. She recalled he had an appointment on 07/05/24. She stated later that day a family member stopped her and asked if she had seen Resident #1. Nurse Aide #1 explained she thought Resident #1 was still at his doctor ' s appointment at that time. She began to help the family member look for him. She asked several staff members if they had seen him, and everyone thought he had not yet returned. Other staff

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members joined the search. They looked in other resident rooms, therapy, activities and the dining room. She recalled the family member said she had talked to the Transporter #1 who told her Resident #1 was in the building. She stated she went to answer a call bell on her assignment and when she came back to help search, Resident #1 and the family member were in his room. She stated she immediately called the Administrator to report that Resident #1 had been left on the van. She verified on her phone that she had called the Administrator at 12:31 PM on 07/05/24 to make the report.

A progress note written by the Nurse Practitioner recorded as a late entry on 07/08/24 at 1:10 PM for 07/05/24 at 3:50 PM documented she was notified by staff that Resident #1 was left on the facility van upon return from an appointment for a period of time up to 10 minutes. She assessed Resident #1 in his room with the family member present. He was in his wheelchair next to the air conditioning vent eating his lunch. His skin color was appropriate for his ethnicity, dry and warm to touch but not hot or feverish. He was not diaphoretic (sweating). He denied nausea, vomiting, abdominal pain or cramping, blurry vision or double vision. He stated his vision was fine. He denied headache, photophobia (sensory disturbance provoked by light) and tinnitus (ringing in ears).

An interview was conducted with the Nurse Practitioner on 07/15/24 at 3:55 PM. She stated Transporter #1 came to her office on 07/05/24, explained she had left Resident #1 on the van, and asked her to come and look at him. A family member was present in the room when she arrived, and Resident #1 was seated in his

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wheelchair in front of the air conditioner. She assessed the resident at that time and found his color was appropriate, his skin was warm but not hot, there were no signs or symptoms of heat stroke, and his neurological assessment was at baseline. He told her he had been really hot in the van. He had no nausea or vomiting and was eating a lunch his family member had brought him. Resident #1 reported to her he had been dizzy when in was in the van. After she assessed Resident #1, she instructed Nurse #1 to take a set of vital signs, check him hourly during the shift, encourage fluids, and monitor output. She noted she also instructed the family to push fluids. She stated she determined because the resident ' s skin was not flushed or pale that he did not need to be sent to the hospital for an assessment. She stated she did not know how long he was on the van because ' 10 minutes ' was told to her by staff so that is what she documented. She did not know the exact time she assessed the resident because she had made her note 3 days later and the time of 3:50 PM was not the actual time she saw Resident #1 on 07/05/24. She stated she did not have a set of vital signs at the time of her assessment but recalled she had instructed Nurse #1 to obtain his vital signs after she completed her assessment. The Nurse Practitioner stated the major risks of being left in a hot vehicle unattended could lead to heat stroke or death.

An interview was conducted with Nurse #1 on 07/15/24 at 3:55 PM. She stated on 07/05/24 after being alerted by staff that Resident #1 was missing she started to help look for him in the facility. The Nurse Practitioner came to her and told her Resident #1 had been left in the van. She stated she went to his room and talked to

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both Resident #1 and the family member. She recalled the resident told her he had been scared. He had been eating the lunch the family brought him.

In an additional interview with Nurse #1 on 07/16/24 at 9:05 AM she stated she had looked through her work bag and found a set of vital signs on a crumpled sticky note that she had taken on Resident #1 on 07/05/24 sometime between 12:30 - 1:00 PM. She stated she knew that the vital signs belonged to Resident #1 because she recalled she had been taking a blood sugar on a different resident when the Nurse Practitioner came to her on 07/05/24 and asked her to stop and go to Resident #1 and get a set of vital signs. Nurse #1 explained she looked at the blood sugars she recorded and determined the time to be 12:35 PM when she was asked to take Resident #1 ' s vital signs. The vital signs she had written down on the sticky note but not recorded in the medical record were blood pressure 126/74, temperature 98.8 degrees F. and heart rate 76 beats per minute. Nurse #1 stated she also monitored Resident #1 frequently throughout the shift, encouraged fluids and monitored his output.

Review of a Psychotherapy Comprehensive Clinical Assessment dated 07/11/24 documented Resident #1 was referred for evaluation after an incident on 07/05/24 in which he was left in the facility transport van after an appointment. Psychologist #1 documented staff reported Resident #1 was accidentally left in the van without air conditioning or windows down for between 10 and 25 minutes. Resident #1 reported to him that he was in the van for as much as 90 minutes, but this was not accurate.

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Resident #1 told him he was extremely frightened and stated: "I thought I was going to die; if my family member hadn ' t been here, I know I would have died." Resident #1 reiterated feeling distressed and worried that he was going to die. Several times he expressed gratitude that his family member was in the facility and able to check on him. Psychologist #1 documented Resident #1 stated, "I ' m OK now; I don ' t think about much about it anymore; I ' m not having any problems." Psychologist #1 recommended a follow-up Psychotherapy assessment in one week to assure ongoing stability.

A concern form filed by the Nursing Home Administrator on behalf of Resident #1 dated 07/05/24 was reviewed. The concern was that Resident #1 had been left unattended on the facility van. The family member, the Social Worker and the Administrator met on 07/12/24. The resolution of the concern included the placement of a no parking sign in the front of the building, education to staff, and the implementation of a walk through on the van by staff prior to parking after a transport.

An interview was conducted with the Administrator on 07/15/24 at 1:35 PM. She stated she had been made aware that Resident #1 had accidentally been left unattended in the van on 07/05/24. She stated Resident #1 had been immediately assessed by the Nurse Practitioner and had no injuries. She noted the family member had been in the facility and was aware Resident #1 had been left in the van. She explained Transporter #1 was suspended on 07/05/24 pending an investigation and returned on 07/08/24 to view van safety videos. The van was put out of commission until 07/11/24. She

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stated the investigation concluded on 07/11/24 and education and competency was completed with Transporter #1. She explained to prevent this from occurring again an audit was developed to have a second staff member perform a walk through and sign off after transports to ensure no one is on the bus for 6 weeks. She stated the Quality Assurance Performance Improvement Committee would review the audits for 6 weeks. The Administrator concluded no resident should ever be left unattended on the facility van.

The Administrator was notified of Immediate Jeopardy on 07/15/24 at 5:35 PM.

The Administrator provided the following corrective action plan with a compliance date of 07/12/24:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On July 5, 2024, Resident #1 was transported into the facility by Transporter #1. Transporter #1 assisted Resident #1 back to the room and got Resident # 1 water. On July 5, 2024, the Nurse Practitioner physically assessed Resident #1. The results of the physical assessment stated that Resident #1 ' s skin color was appropriate for ethnicity, dry and warm to touch but not hot or feverish. Resident #1 ' s temperature was 98.8. The temperature was obtained by Nurse assigned to Resident # 1 at approximately 12:35 p.m. On July 5, 2024, the daughter of Resident #1 was present in the facility and made aware of the incident. On July 11, 2024 Resident #1 was psychologically assessed by Psychiatric Provider with a follow up appointment in one week.

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According to Psychiatric Provider documentation Resident #1 denied any ongoing anxiety related to incident. All future appointments for Resident #1 will be scheduled with a contract transportation company. The root cause analysis was completed on July 8, 2024 by the Administrator and determined that the normal drop off area was blocked. After an extended wait time in the transport area, Transporter #1 left the transport area and parked the van in the parking lot near the maintenance shed and forgot Resident #1 was on the van.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On July 8, 2024, the Administrator reviewed the transportation schedules from June 7, 2024 to July 5, 2024 and interviewed all alert and oriented residents to ensure there were no additional residents left unattended on the facility van. On July 8, 2024, the Director of Nursing and Unit Manager reviewed the medical record of all cognitively impaired residents that were transported by the facility from June 7, 2024 until July 8, 2024 to identify any change in condition that may have been the result of being left unattended on the facility van. No additional residents were affected. In house transport was ceased from July 6, 2024 until July 11, 2024. All resident transportations from July 6, 2024 until July 10, 2024 were completed by a contract transportation company.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

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F 689	Continued From page 17 On July 8, 2024, signs were added to the resident drop off area to discourage visitors and staff from blocking the entrance. The Administrator educated Transporter #1 on July 11, 2024 regarding the new process of ensuring a second staff member validates and signs off on the transport log when residents return to the facility. Administrative staff, which include the Business Office Manager, the Social Worker, the Scheduler, the Activity Assistant, the Admissions Coordinator, the Maintenance Assistant, the facility Receptionist and the Minimum Data Set Nurse were educated on performing a second check upon any resident return from transport by the Administrator on July 8, 2024. The Maintenance Assistant is the only additional person that has been trained to transport residents and he was educated on the process change by the Administrator on July 8, 2024. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Quality Assurance Performance Improvement team reviewed the incident and decided on the plan of correction on July 8, 2024. The Administrator will review the transport logs 5 times per week for 6 weeks to ensure there is a second staff member validating the residents are brought into the facility immediately upon return. The audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for two months to ensure the systemic change is sustainable. The first day of monitoring started on July 11, 2024 when the facility resumed in house transportation. Alleged date of corrective action completion:	F 689		

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F 689	Continued From page 18 7/12/2024 Validation of the corrective action plan was completed on 07/16/24. This included interviews with: Transporter #1, Nurse Practitioner, Nurse #1, Activities Assistant, Business Office Manager, Administrator, Scheduler, Admissions Coordinator, Maintenance Assistant, Receptionist, MDS Nurse and Human Resources Director. These interviews verified that these staff members were trained on the new policy for a second staff member to physically go on the van after transport returns to the facility to ensure no residents are left on the van and that this audit had been implemented. The Nurse Practitioner was interviewed and verified she assessed the resident and there were no injuries. The Resident Representative verified she was aware of the incident when it occurred. Suspension of Transporter #1 during the investigative stage was verified. Transports scheduled between 07/08/24 through 07/10/24 were provided by a community transport service was verified. No transportation was provided until staff had been educated. The facility ' s audit tool, education, and QAPI minutes were reviewed. Two no parking signs were observed in the front of the building near the front door on each side of the awning. The facility ' s immediate jeopardy removal date was verified as 7/6/24 and corrective action completion date was verified as 7/12/24.	F 689		
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.	F 842		8/9/24

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(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

§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

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F 842	Continued From page 20 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 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 record review and staff interviews the facility failed to maintain complete and accurate medical records by not ensuring Nurse #1 documented the vital signs in the medical record for 1 of 5 residents (Resident #1) reviewed for medical record accuracy. The findings included: Resident #1 was admitted to the facility on 05/23/24 with diagnoses that included debility and dementia. A progress note written by the Nurse Practitioner as a late entry on 07/08/24 at 1:10 PM for	F 842	Vital signs for Resident #1 were not entered into the medical record timely. Nurse #1 recorded resident #1's vital signs on a sticky note on 7/5/2024. Nurse #1 entered the vital signs into the medical record on 7/16/2024. On 7/31/2024, an audit was completed from 7/5/2024- 8/7//2024 by Director of nursing/ designee to ensure all residents that have experienced a change in condition have a full set of vital signs documented in the electronic medical record if vital signs were obtained.	

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F 842	Continued From page 21 07/05/24 at 3:50 PM documented she had been notified by staff and nursing that [Resident #1] was left on the facility van upon return from an appointment for a period of time up to 10 minutes. Nursing requested that she evaluate [Resident #1]. An interview was conducted with the Nurse Practitioner on 07/15/24 at 3:55 PM. She stated she had assessed Resident #1 when he was brought back into the facility after he had been left in the van unsupervised. She stated her assessment did not include vital signs but recalled she had instructed Nurse #1 to obtain his vital signs. No vital signs were recorded in the medical record between 12:00 PM and 1:00 PM when Resident #1 was returned to the facility. An interview was conducted with Nurse #1 on 07/15/24 at 3:55 PM. She stated she had been asked to obtain a set of vital signs on Resident #1 at lunchtime on 07/05/24. She recalled the timeframe because she had to stop taking blood sugars to take his vitals. She estimated it was approximately 12:30 PM when she took his vital signs. She stated she had not recorded the vital signs in the electronic medical record. In an additional interview with Nurse #1 on 07/16/24 at 9:05 AM she stated she had found a sticky note in her bag that she had written Resident #1 ' s vital signs on. The vital signs recorded on the sticky note were: Blood pressure 126/74, heart rate 76, and temperature (temple) 98.8 degrees Fahrenheit. There was no date, time, or resident name written on the sticky note. She provided a written statement dated 07/15/24	F 842	On 7/31/2024, education completed with all nurses and providers by the Director of nursing/ designee on documentation accuracy and ensuring documentation is entered timely. The DON/Designee will audit any resident with a change in condition 5 times a week for 12 weeks to ensure vital signs are entered into the medical record. The Quality Assurance Performance Improvement Committee will review the audits monthly for 3 months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance. AOC 8/8/2024	

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attesting to the accuracy of the vital signs taken by her on 07/05/24 for Resident #1.

In an interview with the Director of Nursing on 07/15/24 at 3:55 PM she stated she had not been aware that the vital signs obtained for Resident #1 after he had been left unsupervised in the facility van had not been documented. She explained that she expected all vital signs to be documented in the medical record.

A Record of In-Service form dated 07/15/24 was reviewed on 07/16/24. The title of the in-service was: Documentation. The education was provided by the Director of Nursing to Nurse #1. The objective of the in-service was: Prompt documentation of time sensitive data inclusive of vital sign documentation. Nurse #1 acknowledged in writing that she understood the in-service and had signed the form.