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 10/03/2024

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

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite from 9/24/2024 to 9/26/2024. Additional information was obtained remotely through 10/3/2024. Onsite validation of immediate jeopardy removal was conducted on 10/3/2024. Therefore, the exit date was changed to 10/3/2024. Event ID # TKDF11. The following intakes were investigated NC00222329, NC00222312, NC00222214, NC00222205, NC00222221, NC00221877, NC00221843, NC00221847, NC00221743, NC00221390, NC00221245, NC00221099, NC00220774, NC00220699, NC00220610, and NC00220622. 11 of the 36 allegations resulted in a deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 9/3/2024 and was removed on 10/2/2024. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		10/15/24

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

Electronically Signed | 10/14/2024

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(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations

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F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, medical physician, responsible party, nurse practitioner and paramedic, the facility failed to ensure staff notified the physician when a resident (Resident # 13) was observed by nurse aides to be "zonked," "talking out of his head," "not eating any of his supper meal" and complaining of being tired in conjunction with a new rash observed on multiple areas of his body by multiple staff members. Additionally, one staff member referenced the rash as a "death rash" and thought the physician had already been notified. The resident was transferred to the hospital by emergency services when staff called 911 the following day. The resident was identified to be in septic shock and expired while hospitalized. (Sepsis occurs when an individual's immune system has a wide spread reaction to an infection which can lead to multi system organ failure and is considered life threatening. Septic shock is the last stage of sepsis and results in a low blood pressure). Additionally, the facility failed to notify the responsible party when Resident # 6 had a change in her narcotics. This was for two of five residents who were reviewed for change in condition and or treatment orders (Resident #13 and Resident #6). The findings included: Immediate jeopardy began on 9/3/24 when Resident # 13 was observed to have a rash, which was described by one staff member as a "death rash," on multiple areas of his body in conjunction with a change in his mental status and eating habits without the physician being notified. Immediate jeopardy was removed on 10/2/24 when the facility implemented an	F 580	1. Resident #13 was discharged from the facility on 09/04/2024. On 09/14/2024, Resident #6's Responsible Party was notified of the medication change by the Licensed Nurse. 2. The Director of Nursing and/or designee conducted a 30 day look back to review other residents identified with a change in condition to verify Physician and/or Provider was notified in a timely manner. This review was completed by the Assistant Director of Nursing (ADON) on 10/01/2024 and consisted of a thorough review of change of condition assessments. A change of condition is identified as a significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) Change of Condition assessments are located in our electronic medical record under the user defined assessments in Point Click Care. No additional concerns were identified. The facility determined that all residents have the potential to be affected. An Ad hoc Quality Assurance Performance Improvement Meeting will be held on 10/14/2024 to present the plan of correction for the deficient practice. 3. The Nurse Practice Educator (NPE)	

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F 580	Continued From page 3 acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of D to ensure education is completed and monitoring systems put in place are effective. The facility is being cited at a scope and severity level of D for example # 2 regarding Resident # 6. 1. Resident # 13 was admitted to the facility on 8/5/24. Review of Resident # 13's 8/5/24 hospital discharge summary. The 8/5/24 hospital discharge summary listed the following diagnoses at the time of hospital discharge: proctocolitis (inflammation of the colon and rectum), failure to thrive, hyponatremia, emphysema, lung lesion, abdominal aortic aneurysm, aneurysm of the iliac artery, trochanteric avulsion fracture of the femur, external iliac artery occlusion, compression fracture of thoracic vertebra, compression fracture of lumbar vertebra with delayed healing, and urinary retention. He was discharged to the facility for rehabilitation on 8/5/24. Review of physician orders revealed the resident was a full code. This order remained as an active order until the resident was discharged. Nurse # 5 had cared for Resident # 13 on 9/3/24 from 7:00 AM to 7:00 PM. Nurse # 5 was interviewed on 9/26/24 at 1:40 PM and again on 9/30/24 at 12:15 PM. Nurse # 5 reported the following information. The resident had been voiding and going to the bathroom on 9/3/24. He did not recall any problems with the resident on his shift. Supper trays did not arrive till the end of the shift or after his shift, and he did not recall anyone mentioning to him that Resident #13 was having problems. He knew the resident was planning to go home.	F 580	and/or designee re-educated Licensed Nurses on facility policy Change of Condition: Notification of and Physician/Advanced Practice provider (APP) Notification with emphasis on changes that require immediate physician notification and documentation by 10/01/2024. Changes requiring prompt notification include a significant change in resident physical, mental, or psychosocial status, an accident involving the resident that results in injury or the potential for requiring physician intervention, a need to alter treatment significantly, and a decision to transfer or discharge the resident. Additionally, re-education was completed with Certified Nursing Assistants on early identification of changes in condition and prompt notification of changes to the Licensed Nurse by 10/01/2024. The E-Interact Stop and Watch tool/alert was introduced as an early warning tool to be utilized by direct care givers as another mechanism to communicate changes in condition to the Licensed Nurse. The Director of Nursing and/or Nurse Practice Educator will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, agency staff or PRN staff will be re-educated prior to returning to duty. Starting 10/02/2024, no Licensed Nurse and/or Certified Nurse Aide will be permitted to work until required education is completed prior to the start of their shift. New hires will be educated by the Nurse Practice Educator during the orientation process.	

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F 580	Continued From page 4 NA # 10 had cared for Resident # 13 on the 7:00 AM to 3:00 PM shift on 9/3/24. NA # 10 was interviewed on 9/30/24 at 1:14 PM and reported the resident was fine on her 9/3/24 shift and he was excited because he was planning to go home. There were no nursing progress narrative notes for the date of 9/3/24 or any documentation the physician was consulted about changes in the resident's status. The next nursing narrative in the record was documented on 9/4/24 at 8:47 AM by Nurse # 5 who documented, "Resident sent out to hospital via EMS on a stretcher. Resident presented with altered mental status only responding to name being called with eyes opening. Vitals: 74/41, 42, 97.7, 30 breaths/min (minutes), O2 (oxygen) saturation was undetectable with absent bilateral radial pulses. Rapid, shallow breathing with use of accessory muscles. Resident is full code, notified (provider) at approximately 0805 (8:05 AM) about residents condition and plan to send out to {name of hospital} O2 administered at 3 Liters and monitored with AED (automated external defibrillator) at bedside until EMS arrived at approximately 0815 (8:15 AM).")." (A systolic blood pressure reading of less than 90 or a diastolic blood pressure reading of less than 60 is considered hypotension (low). A normal pulse is 60 to 100. Normal respirations are 12-20.) Nurse Aide (NA) # 8 cared for Resident # 13 from 3:00 PM to 11:00 PM on 9/3/24. NA # 8 was interviewed on 9/27/24 at 12:44 PM and reported the following information. The resident had a rash on his body during her shift. It was on his arms,	F 580	Effective 10/01/2024, the Director of Nursing and/or designee will review changes in condition by reviewing the change in condition assessments, and stop and watch alerts in the morning Clinical Meeting to verify prompt and/or immediate notification is communicated to the Physician and/or Provider. 4. Beginning 10/02/2024, the Director of Nursing and/or designee will conduct quality reviews of notification of changes in condition to verify the Physician and Responsible Party have been notified of changes in condition in a timely manner 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks. The Director of Nursing and/or designee will conduct random quality reviews of narcotic medications to verify the Responsible Party has been notified of changes in narcotic medications in a timely manner 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks. The Director of Nursing and/or designee will review the results of the quality monitoring (audits) in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary. 5. Date of Compliance: 10/15/2024	

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his back, his stomach, and top of his legs. She had never seen the rash on Resident # 13 before when she took care of him, and it was a new problem. He was also "zonked like," "not himself" and did not want to eat. She was able to get him to drink some for supper but he ate nothing at all for his supper meal which was not like him. He usually would eat. The RN Supervisor (Nurse # 9) and Medication Aide (MA) # 1 came into the room to look at the rash that evening before Nurse #8 came on duty. One of them called his name trying to get him to respond. He did look up at that point and they asked him if he itched or was in pain. The resident was able to say no. She thought that someone put him on the physician's board to be seen. Near the end of the shift he "livened up some."

Medication Aide # 1 was interviewed on 9/27/24 at 1:44 PM and reported the following. She had been called by a Nurse Aide to look at Resident # 13 on the evening shift of 9/3/24. He had a rash all over his body in various places. When she looked at the rash a thought process went through her head that it looked like what she had seen before as ringworm, but it was not raised. It was beyond her scope of practice to know what to do and therefore the Nursing Supervisor (Nurse # 9) was called. The resident wanted to be left alone.

Nurse #9 was interviewed initially on 9/27/24 at 2:42 PM and reported she worked all over the facility as the evening shift (3:00 to 11:00 PM supervisor) and did not recall the resident well. She planned to review the record. Nurse #9 did report at that time that if there was something that needed to be communicated to a physician they could call and face time after business hours with

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a provider. If it was not deemed important, then it could be placed on a physician's communication board for a resident to be seen when they arrived at the facility the next time.

Nurse # 9 was interviewed again on 9/30/24 at 12:41 PM and reported after looking at the resident's record she recalled the following information. On the evening of 9/3/24 the resident had a rash that appeared as red circles and white in the middle. To her it did not look like mottling ((discolored patches of skin which can result from a lack of blood flow to the skin). It was on his legs, arms and chest. The resident was sleepy. He did not carry on a conversation but he was able to answer questions. She did not know his baseline well. She did recall someone saying the rash was a "death rash" but she did not recall who said it or when it was said. She felt NA # 8 was a good Nurse Aide. She (Nurse #9) did not recall NA #8 mentioning that the resident did not eat or was "zonked" on the evening shift. According to Nurse #9 that did not mean that NA # 8 did not tell her. She (Nurse #9) could have been told and was not remembering. When she (Nurse #9) looked at Resident # 9's rash she did not take the resident's vital signs. She did not know if others had done so. She did not call the physician on her shift.

On 9/4/24 at 2:39 AM Nurse # 8 documented "a skilled evaluation" which noted the following information. The resident's skin was warm and pink with brisk capillary refill. He was alert and oriented. His pulse registered 70 at 10:52 PM on 9/3/24, respirations16 at 10:52 PM on 9/3/24, oxygen level 100 % at 10:52 PM on 9/3/24. The resident was documented to have brusing on his left forearm and brusing on his left wrist. There

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was no information in the nursing entry regarding any type of rash on the resident's body.

Nurse # 8 had cared for Resident # 13 from 7 PM on 9/3/24 until 7:00 AM on 9/4/24. Nurse # 8 was interviewed on 9/27/24 at 9:44 AM and reported the following information about caring for Resident # 13 on her shift. The resident had a rash on her shift which Nurse # 8 referred to as a "death rash" while being interviewed by the surveyor. When she arrived for work at 7 PM she thought the rash had already been reported to the physician and that the resident had already been checked by the physician. The rash was circular and showed up as redness on his skin. It appeared on his legs and his stomach. When interviewed by the surveyor what the plan was for the "death rash," Nurse # 8 was not sure about that. She did not call the physician about further treatment orders concerning the "death rash." She reported that the resident was stable and she checked his oxygen saturations which were okay. The Nurse Aide (Nurse Aide # 9) who had worked with him during the night shift had also said he was okay. Then at change of shift at 7:00 AM on 9/4/24 when she and another nurse (Nurse # 5), who had come into work at 7:00 AM, were counting controlled substances, a nurse aide approached them. She did not recall which nurse aide. The nurse aide let them know Resident # 13 was awake but would not say anything. She and Nurse # 5 went to the room. She grabbed a crash cart. The resident was "still pink" when they went into the room and they sent him out to the hospital.

NA # 9 had cared for Resident # 13 from 11:00 PM on 9/3/24 until 7:00 AM on 9/4/24. NA # 9 was interviewed on 9/27/24 at 10:00 AM. NA # 9

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reported the following information. The resident was "not doing too well." On rounds through the night, he would say he was okay but would complain of being "tired" and needing sleep. She checked on him each round and would encourage him to get some sleep. He also had a rash. She had never seen anything like it before and remembered asking herself, "What kind of rash is this?" It appeared as big splotches of red. The rash also appeared as "squiggly, squiggly lines" and it was on the resident's stomach, his buttocks and his scrotum. During her last rounds on night shift she asked him if he wanted water and he said "nuh uh" and nothing further.

NA # 10 had cared for Resident # 13 on the 7:00 AM to 3:00 PM shift on 9/4/24. NA # 10 was interviewed on 9/30/24 at 1:14 PM and reported the following information. She did rounds with the night shift NA (NA # 9) when she got to work. They looked in on Resident # 13 during that time. He was not talking at that point. NA #9 said he had not been like that during the night. According to NA # 10 at times the resident did not wake up and talk always and she continued the rounding with NA # 9. Around 8:00 AM she took Resident # 13 his breakfast tray and he would not wake up at that point and eat. She immediately went and got Nurse # 5.

Nurse # 10 was assigned to care for Resident # 13 on the 7 AM to 7 PM shift of 9/4/24. Nurse # 10 was interviewed on 9/30/24 at 11:03 AM and reported 9/4/24 was her second day working at the facility as an agency nurse. Nurse # 10 reported the following information. During report at 7:00 AM, Nurse # 8 had reported that Resident # 13 had a rash since the day before. That was all that was said about the rash. There was

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nothing said that would signify the resident's physician needed to be contacted right away. There was no mention that the rash was a "death rash." After report, a Nurse Aide went to Nurse # 5. (Nurse # 5 was working on the hall, was a routine nurse at the facility, and knew the resident). The Nurse Aide let Nurse # 5 know that something was not right with Resident # 13. She and Nurse # 5 both went in the room. She (Nurse # 10) saw that the resident's breathing was "wacky" and his respirations were in the 40s. Nurse # 5, who routinely worked at the facility knew what to do and called 911. They (she and Nurse # 5) stayed with the resident until EMS arrived. The resident also had mottling on his legs, arms, and chest. Nurse # 8 had not left the facility while she and Nurse # 5 were waiting with the resident and she came into the room. Nurse # 10 reported that it was verified that what Resident # 8 had reported as a "rash" and had been seeing on the previous shift appeared as mottling to her. Nurse # 10 reported it was very evident the resident was mottled.

During the interviews with Nurse # 5 on 9/26/24 at 1:40 M and again on 9/30/24 at 12:15 PM, Nurse # 5 reported the following information. He had already started his medication pass when a Nurse Aide came to get him. He did not recall which Nurse Aide. When he went to check the resident, the resident had mottling on all his extremities. The mottling was very noticeable. His breathing was rapid. The resident was not responding to a sternal rub. His vital signs were very low. He checked his code status and called 911.

Review of EMS records revealed the following information. They were called at 8:05 AM on

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9/4/24. They were at the facility at 8:14 AM and at the resident's side at 8:17 AM. At 8:17 AM the paramedic documented the resident was "nonresponsive." His blood pressure was 89/59, heart rate 121 and respirations 28. They were unable to get a good oxygen reading on him due to his "fingers being cold." The paramedic documented in part, "The nurse in the room stated that normally the patient is talkative is cussing them out however in the last hour he has become non-responsive and starting to breath fast. The patient does not normally wear O2. When I called the resident's name he would flutter his eyes but no other responses. He was very skinny and all of his ribs were showing. He was barrel chested. His skin was pink and looked like it began to model (mottle) on his legs, arms and the lower half of his stomach."

The paramedic, who responded on 9/4/24, was interviewed on 10/1/24 at 4:04 PM and reported the following. Upon her assessment she found Resident # 13 to have mottling on his legs, arms, hands and feet. She described the mottling as blotchy skin, circular, reddish blue. There was no other rash that she saw on the resident's body. The only response he was making was that he would blink his eyes a little to his name. Otherwise he was nonresponsive. He was very thin and looked "very sick" to her.

The hospital ER records, dated 9/4/24, noted the following information. The resident's skin was mottled upon arrival and he was nonresponsive. His systolic blood pressure was in the 70s and they were unable to obtain an oxygen level on him. Fluids, which had been started by EMS, were continued and lab work was done. The resident was intubated (a tube was placed down

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the resident's airway to facilitate breathing) soon after arrival (9:30 AM on 9/4/24). Labs and diagnostic tests were performed. A central line (a long catheter for intravenous fluids which goes to a vein near an individual's heart) was placed at 11:40 AM. The resident was admitted to the Intensive Care Unit (ICU)for care. The resident's admitting ICU note indicated the resident's principle problem was septic shock which was secondary to pneumonia. The resident's chest x-ray showed "multilobar bilateral pulmonary nodular opacity superimposed on emphysema, likely multilobar pneumonia although a component of neoplasm is not excluded." A review of the resident's hospital discharge summary included the following information. The resident expired at the hospital on 9/9/24. While hospitalized his blood cultures had grown MRSA (Methicillin Resistant Staphylococcus Aureus). Sputum cultures had grown staph and pseudomonas. His urine specimen had grown staph and strep. By 9/8/24 he had minimal urine output and remained on full mechanical ventilation. Family was consulted by the hospital staff and the decision was made to make the resident comfort measure only. He was withdrawn from mechanical ventilation and his time of death was listed as 10:05 PM on 9/9/24.

The Director of Nursing was interviewed on 9/27/24 at 4:20 PM, 9/30/24 at 10:17 AM, and 9/30/24 at 1:25 PM and reported the following. It had not been called to her attention that the resident had a "death rash" on 9/3/24 or any problems related to his care before he was transferred out to the hospital. After hours the facility had a telehealth provider who could be called if needed for acute changes in condition. She had looked into the situation after the

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surveyor brought to her attention that the nurse was reporting the resident had a "death rash" on the evening prior to him being transferred to the hospital. She had found that no one had contacted the provider on 9/3/24 or on the morning of 9/4/24 before the resident was in an emergency situation.

Resident # 13's medical physician, who served as the facility's medical director, was interviewed on 9/30/24 at 2:12 PM and again on 10/1/24 at 2:11 PM and reported the following. During the interview, the surveyor shared with the physician the interviews provided by the nursing staff as it related to how the resident's rash had been described in conjunction with what NA # 8 had observed on 9/3/24. The medical director, reported the following. A rash by itself does not warrant immediate urgency or notification to the physician. A rash in conjunction with a change in mental status, change in vitals, any decline can be a red flag and can escalate the need to act. A "death rash" or mottling would indicate someone was in critical condition. If he had been called and told the resident had a rash on the evening of 9/3/24 as described by Nurse # 9, Nurse # 8, NA # 8, and NA # 9 along with information that the resident had been noted by NA #8 not to eat anything for supper, was talking out of his head, and zonked then he would have expected them to do a critical assessment of the resident to determine if fluids needed to be started and he would have had the resident sent out to the hospital. He had reviewed the record also and the vital signs noted in the facility record on 9/4/24 when EMS was summoned would have indicated the resident was in shock at the time EMS was called. Shock can happen quickly as sepsis occurs. The resident was very thin and his

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baseline indicated he was possibly immunocompromised and did not have the reserves a robust person to fight the infection and sepsis. Therefore, he did not feel the outcome would have been different for the resident if they had called the evening prior to 9/4/24.

The facility was notified of immediate jeopardy on 9/30/24 at 5:02 PM.

The facility submitted the following immediate jeopardy removal plan:
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

F-580- Notification of Change in Condition: The facility failed to notify the Physician of a change of condition for Resident #13 in a timely manner and failed to have effective systems in place for Nursing staff to know what changes need to be reported and what needs to be reported immediately.

The Director of Nurses and/or designee conducted a 30 day look back to review other residents identified with a change in condition to verify Physician and/or Provider was notified in a timely manner. This review was completed by the Assistant Director of Nursing (ADON) on October 1, 2024 and consisted of a thorough review of change of condition assessments. A change of condition is identified as a significant change in the patient's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) Change of Condition assessments

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are located in our electronic medical record under the user defined assessments in Point Click Care. No additional concerns were identified.

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

The Nurse Practice Educator (NPE) and/or designee re-educated Licensed Nurses on facility policy Change of Condition: Notification of and Physician/Advanced Practice provider (APP) Notification with emphasis on changes that require immediate physician notification and documentation by October 1, 2024. Changes requiring prompt notification include a significant change in resident physical, mental, or psychosocial status, an accident involving the resident that results in injury or the potential for requiring physician intervention, a need to alter treatment significantly, and a decision to transfer or discharge the resident. Additionally, re-education was completed with Certified Nursing Assistants on early identification of changes in condition and prompt notification of changes to the Licensed Nurse by October 1, 2024. The E-Interact Stop and Watch tool/alert was introduced as an early warning tool to be utilized by direct care givers as another mechanism to communicate changes in condition to the Licensed Nurse. The Director of Nursing and/or Nurse Practice Educator will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, agency staff or PRN staff will be re-educated prior to returning to duty. New hires will be educated by the Nurse Practice Educator during the orientation process. Effective October 1, 2024, the Director of Nursing

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and/or designee will review changes in condition by reviewing the change in condition assessments, and stop and watch alerts in the morning Clinical Meeting to verify prompt and/or immediate notification is communicated to the Physician and/or Provider.

Removal of Immediate Jeopardy is October 2, 2024.

Onsite validation of the immediate jeopardy removal plan was completed on 10/3/24. Interviews confirmed that all staff were educated on significant changes in resident physical, mental, or psychosocial status, an accident involving the resident that results in injury or the potential for requiring physician intervention, a need to alter treatment significantly, and a decision to transfer or discharge the resident. Nurse aides indicated they would notify the nurse about any changes in condition of a resident. Additionally, re-education was completed with Certified Nursing Assistants on early identification of changes in condition and prompt notification of changes to the Licensed Nurse. Training was completed on the E-Interact Stop and Watch tool/alert and passed post testing required. The Stop and Watch tool/alert was successfully used for one resident who experienced shortness of breath. Verification was completed for all staff scheduled to work on 10/3/24 were re-educated prior to returning to duty. Review of documentation revealed 1 resident had a change in condition on 10/2/24 related to a fall; all facility policy and procedures were followed, MD/NP notified, no injury sustained requiring hospitalization.
The immediate jeopardy removal date of 10/2/24 was validated.

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2. Resident #6 had diagnoses of history of dementia, left femur fracture, chronic pain syndrome, and neuropathy.

Documentation on the most recent quarterly Minimum Data Set assessment dated 8/16/2024 revealed Resident #6 was coded as having severe cognitive impairment with scheduled pain medication and receiving opioid pain medication for frequent moderate pain.

Documentation in the physician orders for Resident #6 revealed an order dated as initiated on 7/30/2024 and discontinued on 8/15/2024 for 10 milligrams (mg) of Oxycodone Hydrochloride (HCL) extended release (ER) to be administered as 1 tablet by mouth every 12 hours for pain.

Documentation in the physician order for Resident #6 revealed an order dated as initiated on 8/15/2024 for 15 milligrams of Morphine Sulfate ER to be administered as 1 tablet by mouth every 12 hours for pain. This order was renewed and continued 9/9/2024 through 9/14/2024 for Resident #6.

Documentation in a Nurse Practitioner (NP) #1 progress note dated as initiated on 8/22/2024 and signed 8/25/2024 revealed Resident #6 had an order placed on 8/15/2024 to discontinue the Oxycodone ER and change to Morphine ER for the treatment of chronic pain.

An interview was conducted with NP #1 on 9/25/2024 at 9:21 AM. NP #1 revealed the Responsible Party (RP) for Resident #6 was very involved her care and emailed and communicated with the facility on a regular basis

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her concerns and questions. NP #1 indicated a month prior to the change of Oxycodone ER to Morphine ER for Resident #6, the pharmacy let her know that the medication Oxycodone was requiring prior authorization, and the medication Oxycodone would no longer be covered under her insurance. NP #1 stated she ordered the equivalent of pain medication strength in Morphine for Resident #6 so that she could be kept comfortable. NP #1 stated she puts the orders into the electronic medical record, but it was the responsibility of the nursing staff to notify the RP for Resident #6 of the change in medication. NP #1 did not feel like the medication change had altered Resident #6 in any way other than perhaps making her feel more comfortable allowing her to get more rest.

The RP for Resident #6 was interviewed on 9/24/2024 at 1:11 PM. The RP for Resident #6 provided the following information. Resident #6 had a slow healing femur fracture and had been taking 10 mg of Oxycodone ER twice a day since November of 2023 with no problems. The RP noted a change in Resident #6 in August 2024 in that she was sleepier and not as alert. The RP was notified by the Director of Nursing (DON) on 9/14/2024 via an email Resident #6 had a change in medication from 10 mg Oxycodone ER twice a day to 15 mg Morphine ER twice a day on 8/15/2024. The RP for Resident #6 was not notified of this change in medication until the DON sent her the email after the RP raised concerns.

Nurse #2, the Unit Manager for 100 and 200 halls, was interviewed on 9/25/2024 at 3:05 PM. Nurse #2 stated it was her responsibility to confirm orders written by NP #1 and to notify the

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F 580	Continued From page 18 RP of any changes in the medication to include discontinuation of a medication and new medication orders. Nurse #2 stated she may have overlooked informing the RP of Resident #6 of a medication order change. The DON was interviewed on 9/25/2024 at 1:36 PM. The DON stated she received an email on 9/14/2024 from the RP of Resident #6 inquiring about what medications she was on because Resident #6 seemed drowsier. The DON stated she at that point discovered the RP had not been notified of the medication change from Oxycodone to Morphine for Resident #6. The DON revealed this was an oversight on the part of Nurse #2 and one on one education was provided to Nurse #2. The DON confirmed the facility received notice from the pharmacy the medication Oxycodone was no longer covered by insurance, and they recommended the equivalent of the medication in Morphine ER twice a day for Resident #6. The DON confirmed the RP should be notified of all changes in medication to include dosage, form, and frequency when the change occurs.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		10/15/24

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F 684	Continued From page 19 by: Based on record review, and interviews with staff, physician, and paramedic, the facility failed to ensure staff recognized the need for communication amongst themselves and with the physician to ensure a resident received medical services to address an emergency situation (Resident # 13). Resident # 13 reportedly had a "death rash" in conjunction with nurse aides' observations of him "being zonked," "talking out of his head," "not eating any of his supper meal" and complaining of being tired. The morning following these observations, which were noted by staff members on the previous evening and night shift, the resident was found by the morning shift staff nurses to be without a detectable radial pulse, without a detectable oxygen level, mottled skin (discolored patches of skin which can result from a lack of blood flow to the skin), and not responding to a sternal rub. The resident required emergency transfer to the hospital where he was identified to be in septic shock. (Sepsis occurs when an individual's immune system has a wide spread reaction to an infection which can lead to multi system organ failure and is considered life threatening. Septic shock is the last stage of sepsis and results in a low blood pressure). The resident's blood, sputum, and urine cultures were positive for bacterial growth, and he expired on 9/9/24. The facility also failed to ensure that a resident (Resident # 2) who had sustained a head injury following a fall was assessed by a licensed nurse prior to the resident being moved. This was for two of five sampled residents reviewed for professional standards of practice (Resident #13 and Resident #2). The findings included: Immediate jeopardy began on 9/3/24 when	F 684	1 Resident #13 was discharged from the facility on 09/04/2024. Resident #2 was discharged from the facility on 9/4/24 and no longer resides at the facility. 2. The Licensed Nurses and/or designee completed a head to toe assessment to include vital signs on all residents by 10/01/2024. No additional residents were identified with an emergent change of condition that would require immediate medical attention. An audit was initiated by the Director of Nursing (DON) and/or designee on 09/18/2024 of falls for the past 30 days to ensure that facility NSG215 Falls Management was followed properly with visual observation/validation of the fall interventions according to the residents plan of care are in place to include fall mats as applicable. An Ad hoc Quality Assurance Performance Improvement Meeting will be held on 10/14/2024 to present the plan of correction for the deficient practice. 3. The Nurse Practice Educator and/or designee provided education to Licensed Nurses on how to complete a focused physical assessment to include a thorough skin assessment with vital signs, to include any changes that would require immediate medical attention to include but not limited to; deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical	

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F 684	Continued From page 20 Resident # 13 was observed to have a rash, which was described by one staff member as a "death rash" on multiple areas of his body in conjunction with a change in his mental status and eating habits observed by a nurse aide without staff taking action to ensure the resident received medical care. Immediate jeopardy was removed on 10/2/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. Example # 2, which relates to Resident # 2, is cited at a scope and severity level of D. 1. Resident # 13 was admitted to the facility on 8/5/24. Review of Resident # 13's 8/5/24 hospital discharge summary revealed prior to being admitted to the facility, the resident had been hospitalized from 8/1/24 to 8/5/24 after being found at home in poor living conditions by social services. The hospital discharge summary also contained the following information. Upon hospital admission on 8/1/24 the resident was found to be alert and oriented times three and reported to hospital staff he had not seen a primary physician in 20 years. The resident further reported he had been losing weight for the past year, had not been having a good appetite, and was falling more. He also reported he had been having some fecal incontinence over the past two to three days prior to going to the hospital on 8/1/24. The hospital summary also noted the resident was severely malnourished, weighed 88 pounds, was 5'10" in height, and had chronic alcoholism. A CT (computerized tomography) scan conducted	F 684	complications by 10/01/2024. A post-test was created to validate knowledge and/or comprehension of education. The Director of Nursing, Assistant Director of Nursing and/or Nurse Practice Educator will ensure that the post-test has been completed. The Director of Nursing/Assistant Director of Nursing and/or Nurse Practice Educator will track and verify no Licensed Nurse (s) will be allowed to return to work with scheduled time off, on leave of absence (FMLA), vacation, agency nurses or PRN until they have successful completed the education/training and post-test. Starting 10/02/2024, no Licensed Nurse will be permitted to work until required education is completed prior to the start of their shift. New hires will be educated by the Nurse Practice Educator during the orientation process. The Nurse Practice Educator and/or designee educated Licensed Nurses on the importance of conducting a thorough skin assessment, documenting the assessment, and on specific measures to take if a new skin condition is identified; notifying the Physician/Provider by 10/01/2024. The Director of Nursing and/or Nurse Practice Educator will track and verify Licensed Nurses with scheduled time off, on leave of absence (FMLA), vacation, agency nurses, or PRN staff will be re-educated prior to returning to duty. Starting 10/02/2024, no Licensed Nurse will be permitted to work until required education is completed prior to the start of their shift. New hires will be	

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F 684	Continued From page 21 while the resident was hospitalized showed he had left upper cavitary interstitial scaring and a "soft tissue density and nodularity in the right posterior upper lobe." There was "no discrete solid pulmonary nodules bilaterally" and it was recommended that he have a repeat CT scan in three months to evaluate the scaring in his lungs. Also, according to the hospital discharge summary, the vertebrae compression fractures were mostly chronic, and the left trochanteric fracture was considered acute but of unknown origin date. The resident was deemed to need protected weight bearing for his leg and a walker upon discharge. The 8/5/24 hospital discharge summary listed the following diagnoses at the time of hospital discharge: proctocolitis (inflammation of the colon and rectum), failure to thrive, hyponatremia, emphysema, lung lesion, abdominal aortic aneurysm, aneurysm of the iliac artery, trochanteric avulsion fracture of the femur, external iliac artery occlusion, compression fracture of thoracic vertebra, compression fracture of lumbar vertebra with delayed healing, and urinary retention. He was discharged to the facility for rehabilitation on 8/5/24 with an indwelling catheter for his urinary retention. On 8/7/24 Resident # 13 was seen by Nurse Practitioner (NP) who noted the following information. The resident appeared cachetic (appearance of weight loss and muscle mass loss) and denied any pain or discomfort. He knew he was at the facility for rehabilitation and told the NP he was looking forward to getting stronger. He was aware he had declined before his recent hospitalization of 8/1/24 and reported there had been someone getting groceries for him while he had been at home, but the person did not stay with him all the time. He drank alcohol on a	F 684	educated by the Nurse Practice Educator during the orientation process. The Nurse Practice Educator and/or designee re-educated Certified Nursing Assistants on early identification of changes in condition and prompt notification of changes to the Licensed Nurse by 10/01/2024. The E-Interact Stop and Watch tool/alert was introduced as an early warning tool to be utilized by direct care givers as another mechanism to communicate changes in condition to the Licensed Nurse. The Director of Nursing and/or Nurse Practice Educator will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, agency staff, or PRN staff will be re-educated prior to returning to duty. Starting 10/02/2024, no certified nurse aide will be permitted to work until required education is completed prior to the start of their shift. New hires will be educated by the Nurse Practice Educator during the orientation process. The Nurse Practice Educator and/or designee educated all licensed/certified nursing staff to include; RN/LPN/CMA/CNA, on facility policies NSG215 Falls Management with a post test, NSG234 Safe Resident Handling/Transfer Equipment, as relates to falls management, and OPS100 Accidents/Incidents. Education was completed by 09/23/2024. Effective 10/01/2024, the Director of Nursing and/or designee will review changes in condition by reviewing the	

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regular basis and did not eat much because he was not hungry.

Resident # 13's admission MDS (Minimum Data Set Assessment, dated 8/12/24, coded the resident as cognitively intact and able to independently roll in bed. He was able to walk 10 feet with supervision and or touching. He was independently able to go from a lying in bed to a sitting position. He required partial to moderate assistance with his bathing and hygiene needs.

Review of physician orders revealed the resident was a full code. This order remained in effect through the resident's discharge.

On 8/14/24 Resident # 13 was seen again by the NP who noted the following information. He reported feeling well and was attending therapy which he knew would help him get stronger. He reported he had been eating and drinking better since admission. He was afebrile and his heart rate and blood pressure were stable.

The Nurse Practitioner was interviewed on 10/2/24 at 3:52 PM and reported the following. She had never seen a resident with such a low BMI (body mass index) reading and felt that signified he was not a well person. The last time she assessed Resident # 13 was on 8/14/24 and he indicated he was trying to eat better and get stronger. It was only about two weeks into his stay and it was too soon to determine how he would progress.

Weight records for Resident # 13 included in part the following information showing the resident gained weight since admission up until 8/28/24.
8/5/24-88 pounds

change in condition assessments, in the morning Clinical Meeting to verify a thorough assessment has been completed.

4. Beginning 10/02/2024, the Director of Nursing and/or designee will conduct quality reviews of any changes in condition to ensure an assessment of the resident was completed 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks.

The Director of Nursing and/or designee will conduct quality reviews of falls to ensure that the resident is assessed by a Licensed Nurse prior to being moved 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks.

The Director of Nursing and/or designee will review the results of the quality monitoring (audits) in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.

5. Date of Compliance: 10/15/2024

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8/21/24-94 pounds
8/22/24-94.1 pounds
8/23/23-94 pounds
8/28/24-97.2 pounds

On 8/30/24 at 5:44 PM Nurse # 4 documented Resident # 13 was complaining of his catheter feeling weird during the shift of 7AM to 7PM. He had been found to have some swelling in his groin which he reported had happened before. The catheter was deflated and removed, and the resident refused to have the catheter reinserted. He was voiding in a urinal. The physician had been contacted and reported to monitor the resident and send him out if he had pain or problems voiding.

Following Nurse # 4's note, there was no order entered into the electronic record to discontinue the catheter. There were no nursing progress notes documenting voiding patterns or problems with the resident's groin.

On 9/3/24 at 4:24 PM the social worker entered a progress note documenting that she made a phone call to the resident's first family contact to "set up discharge" for the resident and left a voice mail.

The facility social worker was interviewed on 10/2/24 at 3:49 PM and reported the following information. The resident's insurance had changed and he was wanting to go home on 9/5/24. He had not completed his therapy goals yet and the facility felt it would be against medical advice. They wanted him to be completely independent before going home. He was walking with a walker but was unsteady. Prior to his hospitalization he had some home health

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services a few times per week. She had placed a phone call to the resident's family member on 9/3/24 to talk about the resident's choice to discharge on 9/5/24. He had informed the facility staff that he was able to go home alone and no longer wanted to stay.

There were no nursing progress narrative notes for the date of 9/3/24.

Nurse # 5 had cared for Resident # 13 on 9/3/24 from 7:00 AM to 7:00 PM. Nurse # 5 was interviewed on 9/26/24 at 1:40 PM and again on 9/30/24 at 12:15 PM. Nurse # 5 reported the following information. The resident had been voiding and going to the bathroom on 9/3/24. He did not recall any problems with the resident on his shift. Supper trays did not arrive until the end of the shift or after his shift, and he did not recall anyone mentioning to him that Resident #13 was having problems. He knew the resident was planning to go home.

NA # 10 had cared for Resident # 13 on the 7:00 AM to 3:00 PM shift on 9/3/24. NA # 10 was interviewed on 9/30/24 at 1:14 PM and reported the resident was fine on her 9/3/24 shift and he was excited because he was planning to go home.

Physical Therapist # 1 was interviewed on 9/27/24 at 1:56 PM and reported the following information. The resident participated in therapy on 9/3/24 by doing leg kicks while sitting on the side of the bed. He had a chronic cough. She did not do any exercises that would aggravate his cough. He would do chin to chest posturing to compensate for any breathing problems and therefore he tolerated his rehab session okay. He

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was able to converse during his therapy session on 9/3/24. The resident was wearing a hospital gown and she could see his legs. There was no rash on his legs or discoloration during the therapy session.

Nurse Aide (NA) # 8 cared for Resident # 13 from 3:00 PM to 11:00 PM on 9/3/24. NA # 8 was interviewed on 9/27/24 at 12:44 PM and reported the following information. The resident had a rash on his body during her shift. It was on his arms, his back, his stomach, and top of his legs. She had never seen the rash on Resident # 13 before when she took care of him, and it was a new problem. He was also "zonked like," "not himself" and did not want to eat supper. She was able to get him to drink some for supper but he ate nothing at all for his supper meal which was not like him. He usually would eat. The RN Supervisor (Nurse # 9) and Medication Aide (MA) # 1 came into the room to look at the rash that evening before Nurse #8 came on duty. One of them called his name trying to get him to respond. He did look up at that point and they asked him if he itched or was in pain. The resident was able to say no. She thought that someone put him on the physician's board to be seen.

Medication Aide # 1 was interviewed on 9/27/24 at 1:44 PM and reported the following. She had been called by a Nurse Aide on the evening of 9/3/24 to look at Resident # 13 on the evening shift of 9/3/24. He had a rash all over his body in various places. When she looked at the rash a thought process went through her head that it looked like what she had seen before as ringworm, but it was not raised. It was beyond her scope of practice to know what to do and

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therefore the Nursing Supervisor (Nurse # 9) was called. The resident wanted to be left alone.

Nurse #9 was interviewed initially on 9/27/24 at 2:42 PM and reported she worked all over the facility as the evening shift (3:00 to 11:00 PM supervisor) and did not recall the resident well. She planned to review the record. Nurse #9 did report at that time that if there was something that needed to be communicated to a physician they could call and face time after business hours with a provider. If it was not deemed important, then it could be placed on a physician's communication board for a resident to be seen when they arrived at the facility the next time.

Nurse # 9 was interviewed again on 9/30/24 at 12:41 PM and reported after looking at the resident's record she recalled the following information. On the evening of 9/3/24 the resident had a rash that appeared as red circles and white in the middle. To her it did not look like mottling. It was on his legs, arms and chest. The resident was sleepy. He did not carry on a conversation but he was able to answer questions. She did not know his baseline well. She did recall someone saying the rash was a "death rash" but she did not recall who said it or when it was said. She felt NA # 8 was a good Nurse Aide. She (Nurse #9) did not recall NA #8 mentioning that the resident did not eat or was "zonked" on the evening shift. According to Nurse #9 that did not mean that NA # 8 did not tell her. She (Nurse #9) could have been told and was not remembering. When she (Nurse #9) looked at Resident # 9's rash she did not take the resident's vital signs. She did not know if others had done so. She did not call the physician on her shift.

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On 9/4/24 at 2:39 AM Nurse # 8 documented "a skilled evaluation" which noted the following information. The resident's skin was warm and pink with brisk capillary refill. He was alert and oriented. His pulse registered 70 at 10:52 PM on 9/3/24, respiratons16 at 10:52 PM on 9/3/24, oxygen level 100 % at 10:52 PM on 9/3/24. The resident was documented to have brusing on his left forearm and brusing on his left wrist. The nurse also entered the resident's catheter was intact (which was incorrect given that the resident's catheter had been removed and never replaced). There was no information in the nursing entry regarding any type of rash on the resident's body. There was no blood pressure reading documented within this entry.

Nurse # 8 had cared for Resident # 13 from 7 PM on 9/3/24 until 7:00 AM on 9/4/24. Nurse # 8 was interviewed on 9/27/24 at 9:44 AM and reported the following information about caring for Resident # 13 on her shift. The resident had a rash on her shift which Nurse # 8 referred to as a "death rash" while being interviewed by the surveyor. When she arrived for work at 7 PM she thought the rash had already been reported to the physician and that the resident had already been checked by the physician. The rash was circular and showed up as redness on his skin. It appeared on his legs and his stomach. When interviewed by the surveyor what the plan was for the "death rash," Nurse # 8 was not sure about that. She knew he was very malnourished and they were supposed to try to get him to eat. He typically would eat things like oatmeal cakes and kool-aid rather than nutritious food. Through the night he was stable and she checked his oxygen saturations which were okay. The Nurse Aide who had worked with him during the night shift

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had also said he was okay.

NA # 9 had cared for Resident # 13 from 11:00 PM on 9/3/24 until 7:00 AM on 9/4/24. NA # 9 was interviewed on 9/27/24 at 10:00 AM. NA # 9 reported the following information. The resident was "not doing too well." On rounds through the night, he would say he was okay but would complain of being "tired" and needing sleep. She checked on him each round and would encourage him to get some sleep. He also had a rash. She had never seen anything like it before and remembered asking herself, "What kind of rash is this?" It appeared as big splotches of red. The rash also appeared as "squiggly, squiggly lines" and it was on the resident's stomach, his buttocks and his scrotum. During her last rounds on night shift she asked him if he wanted water and he said "nuh uh" and nothing further.

NA # 10 had cared for Resident # 13 on the 7:00 AM to 3:00 PM shift on 9/4/24. NA # 10 was interviewed on 9/30/24 at 1:14 PM and reported the following information. She did rounds with the night shift NA (NA # 9) when she got to work. They looked in on Resident # 13 during that time. He was not talking at that point. NA #9 told NA #10 he had not been like that during the night. According to NA # 10 at times the resident did not wake up and talk always and she continued the rounding with NA # 9. Around 8:00 AM she took Resident # 13 his breakfast tray and he would not wake up at that point and eat. She immediately went and got Nurse # 5.

Nurse # 10 was assigned to care for Resident # 13 on the 7 AM to 7 PM shift of 9/4/24. Nurse # 10 was interviewed on 9/30/24 at 11:03 AM and reported 9/4/24 was her second day working at

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the facility as an agency nurse. Nurse # 10 reported the following information. During report at 7:00 AM, Nurse # 8 had reported that Resident # 13 had a rash since the day before. That was all that was said about the rash. There was nothing said that would signify the resident was in need of urgent medical attention. There was no mention that the rash was a "death rash." After report, a Nurse Aide went to Nurse # 5. (Nurse # 5 was working on the hall, was a routine nurse at the facility, and knew the resident). The Nurse Aide let Nurse # 5 know that something was not right with Resident # 13. She and Nurse # 5 both went in the room. She (Nurse # 10) saw that the resident's breathing was "wacky" and his respirations were in the 40s. She could not recall how responsive he was. Nurse # 5, who routinely worked at the facility knew what to do and called 911. They (she and Nurse # 5) stayed with the resident until EMS arrived. The resident also had mottling on his legs, arms, and chest. Nurse # 8 was still at the facility and had not gone home yet when Nurse # 5 and Nurse # 10 assessed Resident # 13. Nurse # 8 came into the room after Nurse # 10 and Nurse # 5 were in the room. Nurse # 10 reported what Nurse # 8 had reported as a "rash" on the previous shift appeared as mottling to her. Nurse # 10 reported it was very evident the resident was mottled.

The next nursing narrative in the record was documented on 9/4/24 at 8:47 AM by Nurse # 5 who documented, "Resident sent out to hospital via EMS on a stretcher. Resident presented with altered mental status only responding to name being called with eyes opening. Vitals: 74/41, 42, 97.7, 30 breaths/min (minutes), O2 (oxygen) saturation was undetectable with absent bilateral radial pulses. Rapid, shallow breathing with use

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of accessory muscles. Resident is full code, notified (provider) at approximately 0805 (8:05 AM) about residents condition and plan to send out to {name of hospital} O2 administered at 3 Liters and monitored with AED (automated external defibrillator) at bedside until EMS arrived at approximately 0815 (8:15 AM)." (A systolic blood pressure reading of less than 90 or a diastolic blood pressure reading of less than 60 is considered hypotension (low). A normal pulse is 60 to 100. Normal respirations are 12-20.)

During the interview with Nurse # 8 on 9/27/24 at 9:44 AM the nurse reported the following information about the end of her shift which ended on 9/4/24 at 7:00 AM. At change of shift at 7:00 AM on 9/4/24 when she and another nurse (Nurse # 5), who had come into work at 7:00 AM, were counting controlled substances, a Nurse Aide approached them. She did not recall which Nurse Aide approached them. The Nurse Aide let them know Resident # 13 was awake but would not say anything. She and Nurse # 5 went to the room. She grabbed a crash cart. The resident was "still pink" when they went into the room and they sent him out to the hospital.

During the interviews with Nurse # 5 on 9/26/24 at 1:40 PM and again on 9/30/24 at 12:15 PM, Nurse # 5 reported the following information. He was working the dayshift on 9/4/24. He had already started his medication pass when a Nurse Aide came to get him. He did not recall which Nurse Aide. When he went to check the resident, the resident had mottling on all his extremities. The mottling was very noticeable. His breathing was rapid. From the extent of the mottling, he (Nurse # 5) was not sure how it had gone undetected during the night shift. The night

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shift had reported that there was nothing wrong with the resident. The resident was not responding to a sternal rub. His vital signs were very low. He checked his code status and called 911. Nurse # 8 "had her bag" and was headed out the door. She did get the crash cart for him and Nurse # 10 before she left. He and Nurse # 10 stayed with the resident until EMS arrived. Night shift had reported to dayshift that the resident had been okay during the night.

Review of EMS records revealed the following information. They were called at 8:05 AM on 9/4/24 (which was an hour and five minutes after the change of shift from night shift to day shift). They were at the facility at 8:14 AM and at the resident's side at 8:17 AM. At 8:17 AM the paramedic documented the resident was "nonresponsive." His blood pressure was 89/59, heart rate 121 and respirations 28. They were unable to get a good oxygen reading on him due to his "fingers being cold." The paramedic documented in part, "The nurse in the room stated that normally the patient is talkative is cussing them out however in the last hour he has become non-responsive and starting to breath fast. The patient does not normally wear O2. When I called the resident's name he would flutter his eyes but no other responses. He was very skinny and all of his ribs were showing. He was barrel chested. His skin was pink and looked like it began to model (mottle) on his legs, arms and the lower half of his stomach. Patient was placed on 15L O2 NRB (oxygen by nonrebreather). The patients' vitals were obtained along with a BGL (blood glucose level). BGL was normal limits but the patient was hypotensive. I asked the patient staff at [name of facility} have they noticed anything new about the patient's

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daily life with them and they stated that he has not been wanting to eat or drink hardly and yesterday when they needed to place a {indwelling} catheter in him because he was not producing urine he refused. 12 lead (heart monitoring leads) placed on the patient and it read Afib. (a type of heart arrhythmia) 20 gauge IV (intravenous) obtained in the patient's right AC (anticubital). Patient was then moved with a drawsheet to the stretcher and secured. His respirations slowed down and he started to belly breath. Patient then taken to the ambulance where he was loaded and secured. Lactated Ringers (a type of intravenous fluid) started on the patient, wide open. The patient began snoring respirations again. Vitals obtained and his blood pressure went lower ....." According to the paramedic's report they transferred care to the hospital staff at 9:03 AM on 9/4/24.

The paramedic, who responded on 9/4/24, was interviewed on 10/1/24 at 4:04 PM and reported the following. Upon her assessment she found Resident # 13 to have mottling on his legs, arms, hands and feet. She described the mottling as blotchy skin, circular, reddish blue. There was no other rash that she saw on the resident's body. The only response he was making was that he would blink his eyes a little to his name. Otherwise he was nonresponsive. He was very thin and looked "very sick" to her.

The hospital ER records, dated 9/4/24, further noted the following information. The resident's skin was mottled upon arrival and he was nonresponsive. His systolic blood pressure was in the 70s and they were unable to obtain an oxygen level on him. Fluids, which had been started by EMS, were continued and lab work was done.

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The resident was intubated (a tube is placed down their airway to facilitate breathing) soon after arrival (9:30 AM on 9/4/24). Labs and diagnostic tests were performed. A central line (a long catheter for intravenous fluids which goes to a vein near an individual's heart) was placed at 11:40 AM. The resident was admitted to the Intensive Care Unit (ICU) for care. The resident's admitting ICU note indicated the resident's principle problem was septic shock which was secondary to pneumonia. The resident's chest x-ray showed "multilobar bilateral pulmonary nodular opacity superimposed on emphysema, likely multilobar pneumonia although a component of neoplasm is not excluded." A review of the resident's hospital discharge summary included the following information. The resident expired at the hospital on 9/9/24. While hospitalized his blood cultures had grown MRSA (Methicillin Resistant Staphylococcus Aureus). Sputum cultures had grown staph and pseudomonas. His urine specimen had grown staph and strep. By 9/8/24 he had minimal urine output and remained on full mechanical ventilation. Family was consulted by the hospital staff and the decision was made to make the resident comfort measure only. He was withdrawn from mechanical ventilation and his time of death was listed as 10:05 PM on 9/9/24.

The Director of Nursing was interviewed on 9/27/24 at 4:20 PM, 9/30/24 at 10:17 AM, and 9/30/24 at 1:25 PM and reported the following. It had not been called to her attention that the resident had a "death rash" on 9/3/24 or any problems related to his care before he was transferred out to the hospital. After hours the facility had a telehealth provider who could be called if needed for acute changes in condition.

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She had looked into the situation after the surveyor brought to her attention that the nurse was reporting the resident had a "death rash" on the evening prior to him being transferred to the hospital. She had found that no one had contacted the provider on 9/3/24. The information that he had a rash had been put in the binder where information is left for the provider to request a resident be seen when they next come. She had talked to Nurse # 8 who reported that she did not see anything life threatening on the night shift of 7 PM to 7 AM beginning on 9/3/24. The DON had questioned Nurse # 8 about why she had used the term "death rash" to describe the rash she saw to the surveyor. After thinking more Nurse #8 thought maybe she had later heard after the resident was transferred to the hospital that what he had been experiencing was a death rash.

Resident # 13's medical physician, who served as the facility's medical director, was interviewed on 9/30/24 at 2:12 PM and again on 10/1/24 at 2:11 PM and reported the following. During the interview, the surveyor shared with the physician the interviews provided by the nursing staff as it related to how the resident's rash had been described in conjunction with what NA # 8 had observed on 9/3/24. The medical physician reported the following. A rash by itself does not warrant immediate urgency or notification to the physician. A rash in conjunction with a change in mental status, change in vitals, any decline can be a red flag and can escalate the need to act. A "death rash" or mottling would indicate someone was in critical condition. The medical director was interviewed about actions that would have been taken if he had been called and told the resident had a rash on the evening of 9/3/24 as described

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by Nurse # 9, Nurse # 8, NA # 8, and NA # 9 along with information that the resident had been noted by NA #8 not to eat anything for supper, was talking out of his head, and zonked. The medical director reported he would have expected them to do a critical assessment of the resident to determine if fluids needed to be started and he would have had the resident sent out to the hospital. The medical director further reported the following information. He had reviewed the record also and the vital signs noted in the facility record on 9/4/24 when EMS was summoned would have indicated the resident was in shock at the time EMS was called. Shock can happen quickly as sepsis occurs. The resident was very thin and his baseline indicated he was possibly immunocompromised and did not have the reserves a robust person to fight the infection and sepsis. Therefore, he did not feel the outcome would have been different for the resident if they had called the evening prior to 9/4/24.

The facility was notified of immediate jeopardy on 9/30/24 at 5:02 PM.

The facility submitted the following immediate jeopardy removal plan:
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

F-684- Quality of Care: Nursing staff failed to recognize when a resident experienced a change in condition warranting immediate action.

" The Licensed Nurses and/or designee completed a head to toe assessment to include

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vital signs on all residents by October 1, 2024. No additional residents were identified with an emergent change of condition that would require immediate medical attention.

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

" The Nurse Practice Educator and/or designee will provide education to Licensed Nurses on how to complete a focused physical assessment to include a thorough skin assessment with vital signs, to include any changes that would require immediate medical attention to include but not limited to; deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications by October 1, 2024. A post-test has been created and is in progress to validate knowledge and/or comprehension of education. The Director of Nursing, Assistant Director of Nursing and/or Nurse Practice Educator will ensure that the post-test have been completed. The Director of Nursing/Assistant Director of Nursing and/or Nurse Practice Educator will track and verify no Licensed Nurse (s) will be allowed to return to work with scheduled time off, on leave of absence (FMLA), vacation, agency nurses or PRN until they have successful completed the education/training and post-test. Starting 10/2/2024, no licensed nurse will be permitted to work until required education is completed prior to the start of their shift. New hires will be educated by the Nurse Practice Educator during the orientation process.

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" The Nurse Practice Educator and/or designee will educate Licensed Nurses on the importance of conducting a thorough skin assessment, documenting the assessment, and on specific measures to take if a new skin condition is identified; notifying the Physician/Provider by October 1, 2024. The Director of Nursing and/or Nurse Practice Educator will track and verify Licensed Nurses with scheduled time off, on leave of absence (FMLA), vacation, agency nurses, or PRN staff will be re-educated prior to returning to duty. Starting 10/2/2024, no licensed nurse will be permitted to work until required education is completed prior to the start of their shift. New hires will be educated by the Nurse Practice Educator during the orientation process.

" The Nurse Practice Educator and/or designee re-educated Certified Nursing Assistants on early identification of changes in condition and prompt notification of changes to the Licensed Nurse by October 1, 2024. The E-Interact Stop and Watch tool/alert was introduced as an early warning tool to be utilized by direct care givers as another mechanism to communicate changes in condition to the Licensed Nurse. The Director of Nursing and/or Nurse Practice Educator will track and verify that employees with scheduled time off, on leave of absence (FMLA), vacation, agency staff, or PRN staff will be re-educated prior to returning to duty. Starting 10/2/2024, no certified nurse aide will be permitted to work until required education is completed prior to the start of their shift. New hires will be educated by the Nurse Practice Educator during the orientation process.

" Effective October 1, 2024, the Director of Nurses and/or designee will review changes in condition by reviewing the change in condition

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assessments, in the morning Clinical Meeting to verify a thorough assessment has been completed.
" Removal of Immediate Jeopardy October 2, 2024.

Onsite validation of the immediate jeopardy removal plan was completed on 10/3/24. Interviews conducted confirmed all licensed nurses received training on skin assessments and how to conduct a skin assessment. All nursing staff completed a skin assessment clinical competency validation and completed a skin assessment posttest. All residents received a skin assessment, and any issues identified were forwarded to the facility wound nurse or MD/NP. A new Interim Director of Nursing stated one resident had been admitted on 10/2/24. Record review revealed the newly admitted resident received a skin assessment as described in the facility's procedures. The immediate jeopardy removal date of 10/2/24 was validated.

2. Resident # 2 resided at the facility from 11/30/16 until her final discharge on 9/4/24. The resident in part had diagnoses which included stroke, atherosclerotic heart disease, osteoporosis, dementia with behavioral disturbance, contracture of the left and right leg, history of hallucinations, and anxiety.

Resident # 2's quarterly MDS (Minimum Data Set) assessment, dated 8/16/24, coded the resident as rarely/never understood and unable to complete an interview for cognition. The resident was coded as being totally dependent on staff for bathing, dressing, and hygiene needs. The

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resident was also coded as needing total staff assistance to turn in bed, go from a sitting to lying position, and for transfers.

Review of Resident # 2's care plan, dated 8/30/24 revealed staff had identified the resident was at risk for falls.

Review of Resident # 2's record revealed a SBAR (situation, background, appearance, and review) progress note form completed by Nurse # 8 on 9/4/24 at 7:07 AM. The situation was noted to be a fall on 9/4/24. There was not a specific time of the fall. The nurse documented, "Upon hearing a loud noise like a fall, the CNA found the resident on the floor at her bedside. Resident was assessed and assisted back to bed. Resident had a large bump on her forehead and a skin tear on both right and left leg." Nurse # 8 further noted the resident's vital signs were as follows: blood pressure 117/63, pulse 76, respirations 18, and temperature 97.4. Nurse # 4 documented the provider was notified on 9/4/24 at 6:05 AM with orders to send the resident to the ER (emergency room).

NA # 7 had cared for Resident # 2 on the shift which began at 11:00 PM on 9//3/24 and which ended at 7:00 AM on 9/4/24. NA # 7 was interviewed on 9/24/24 at 3:22 PM and reported the following information. Around 5:30 AM she was making rounds and found the resident on the floor. The resident was on the floor near the air and heating unit. Her head was in a pool of blood. There were two skin tears to her legs which appeared to not be new but had reopened. NA # 7 looked and could find no one to help her with the resident. She did not want to leave the resident lying there. She therefore picked the

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resident up and placed her back in the bed. She was with her for about 20 minutes when MA # 1 came in the room.

MA # 1 was interviewed on 9/24/24 at 4:45 PM and reported the following information. She had been assigned to Resident # 2 when the resident had sustained a fall. She had walked into the room to administer medications to Resident # 2's roommate. At the time, the curtain was partially closed and she (MA # 1) could only see Resident # 2's legs when she entered the room. She could see blood on the resident's leg. She walked completely around the curtain to Resident # 2's side of the room. She (MA # 1) also saw a towel with blood on it and the resident had a head injury. When she saw blood, she knew it was beyond her scope of practice and she went to get the Nurse (Nurse #8) who was covering for her. Nurse # 8 called 911 and bandaged Resident # 2's head so that it would not bleed further.

Nurse # 8 was the nurse covering for MA # 1 on the night from 7:00 PM to 7:00 AM. Nurse # 8 was interviewed on 9/24/24 at 8:20 PM and reported the following information. MA # 1 had asked her to check Resident # 2 on the date of the incident. When she entered the room, she asked NA # 7 what had happened, and NA # 7 said she found the resident on the floor. NA # 7 had also reported she had placed the resident back in bed. At the time of her (Nurse #8's) assessment, the resident had a little blood on her forehead and an open skin tear to her right and left leg. She (Nurse #8) applied dressings, obtained vitals, and sent the resident to the hospital.

Review of hospital ER records, dated 9/4/24,

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F 684	Continued From page 41 revealed the following documentation. The resident was "presenting from her nursing facility after fall. Patient is hemodynamically stable and nontoxic-appearing on arrival. She has significant trauma to the face including significant ecchymosis and periorbital ecchymosis and abrasions of the right foot and we will x-ray those was well." Following testing on 9/4/24, the ER physician noted the following information. "Patient's lab work and CT imaging showed no traumatic injuries other than a nasal bone fracture. Patient will be given ENT (ears nose throat) follow up. She does have significant bruising and edema of the face. Steri-strips were placed over a skin abrasion on the forehead. Patient otherwise remained at baseline." According to the hospital record, Resident # 2 was discharged to another facility.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, and interviews with staff and Responsible Party the facility failed to follow	F 685	1. The Director of Social Services held a care plan meeting on 10/07/2024 in	10/15/24

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F 685	Continued From page 42 up with an audiologist's recommendation when one of Resident # 5's hearing aids was lost and the other broken. This was for one of one sampled resident with hearing loss (Resident #5). The findings included: Resident # 5 was admitted to the facility on 1/29/24. The resident had diagnoses in part which included stroke and dementia. The resident's quarterly Minimum Data Set assessment, dated 7/30/24, coded the resident as cognitively impaired, having impaired hearing, and as wearing no hearing aids. The resident's care plan, updated on 8/2/24, included the problem that the resident had impaired hearing. The care plan also included the information that Resident # 5's RP (Responsible Party) had reported the resident had hearing aids, but they were not working. This had been initially added to the care plan on 1/30/24 and remained part of the resident's active care plan. Review of the interventions on the care plan revealed staff were directed on the care plan in ways to communicate with the resident, but there were no interventions related to steps needed to take about the resident's malfunctioning hearing aids. Review of an audiology report, dated 9/6/24, revealed Resident # 5 was seen for a "hearing aid check." The audiologist noted, "The patient stated that the right one is lost, and the left one doesn't work." Under the audiologist evaluation detail, the following information was documented. " Left hearing aid is intermittent. The receiver is damaged. Unsure of warranty of devices. Does it have a warranty? Could it get repaired and could they file loss/damage claim with company for a	F 685	Resident #5 's room with the resident's Responsible Party/Legal Guardian and Next of Kin present. The missing/broken hearing aides were discussed. The Director of Social Services and/or designee will schedule follow-up audiology appointment for Resident #5 by 10/14/2024. 2. The Director of Social Services and/or designee conducted an audit of residents identified who participated in audiology clinics for the last three quarters and reviewed consultation notes and/or recommendation to verify follow up was executed by 10/14/2024. Any concerns identified were addressed and documented in the medical record. An Ad hoc Quality Assurance Performance Improvement Meeting will be held on 10/14/2024 to present the plan of correction for the deficient practice. 3. The Nursing Home Administrator and/or designee will educate the Director of Social Services, The Director or Nursing, and Licensed Nurses on initiating timely follow up and resolution of auditory consultations and/or recommendations by 10/11/2024. Policy SS102 Communication of Special Needs and Policy SS106 Referrals to Community Based Services was also reviewed in this re-education. New Licensed Nurses will be educated by the Nurse Practice Educator and/or designee during the orientation process.	

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F 685	Continued From page 43 new right device?" Directions on the consult indicated there needed to be follow up with the family to determine what the warranty information and repair information was for the hearing aid that was lost and the one that was damaged. Review of the record revealed no documentation the follow up had been conducted since 9/6/24. Resident # 5's RP (Responsible Party was interviewed on 9/24/24 at 8:38 PM and reported the following information. The resident had one hearing aid but that one did not help her hear. She used to have both hearing aids, but at some point, one of them became missing. The missing one was the one that she needed most to hear. It had been around 3 to 4 months since one of them had been lost. She (the RP) had talked to someone "in the front office" and it was her understanding that the facility was supposed to be checking on getting the resident new hearing aids. She (the RP) had been told that the resident would qualify for new hearing aids, but there had been no follow through, and the resident still had no hearing aids she could use. On 9/25/24 at 3:35 PM the ADON (Assistant Director of Nursing) was accompanied to Resident # 5's room. Resident # 5 was observed to be hard of hearing. In order for the resident to hear, the speaker had to talk very loudly to the resident and face the resident. The ADON located one hearing aide in the resident's room and the other was missing. The ADON was unaware about the steps being taken about the missing hearing aid. The facility social worker was interviewed on 9/26/24 at 2:30 PM and reported the following	F 685	The Director of Social Services and/or designee will review results of auditory consultation in the morning meeting to communicate needed follow up and resolution. 4. The Director of Social Services and/or designee will conduct quality reviews of auditory consultations to ensure follow up is executed as necessary 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks. The Nursing Home Administrator and/or designee will review the results of the quality monitoring (audits) in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary. 5. Date of Compliance: 10/15/2024	

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F 685	Continued From page 44 information. She (the social worker) had begun work in May 2024 and was still somewhat new. She was responsible for setting up hearing clinics at the facility. Resident # 5 had a care plan meeting in August 2024, and the RP mentioned the resident had hearing problems and needed hearing aids. The first hearing clinic that she (the social worker) had arranged since being employed was in September 2024. She had informed the RP that a consult would be set up and the resident would be seen in the hearing aid clinic. The Administrator and Director of Nursing were interviewed on 9/25/24 at 3:20 PM and reported they were unaware of problems with the resident's hearing aids. They indicated they would check on what had occurred. A follow up interview was conducted with the Administrator on 9/26/24 at 8:30 AM and the Administrator reported the following information. The audiologist had filed their consult with the recommendations directly into Resident # 5's facility electronic record without letting any of the staff know. Therefore, they had been unaware follow up needed to be done about warranty information until the issue had been brought to their attention on 9/25/24 by the surveyor that there had been a problem with the resident's hearing aids.	F 685		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 45 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, Responsible Party, Nurse Practitioner and Medical Director the facility failed to 1) ensure staff were providing transfer assistance as care planned for a resident (Resident # 1) identified as at risk for injuries due to osteoporosis and 2) ensure mats were at the bedside to prevent injuries for a resident with a history of falls (Resident # 2). Resident # 2 sustained a large hematoma and fractured nose when she was found on the floor without a fall mat in place. This was for two of three sampled residents reviewed for accidents (Resident #1 and Resident #2). The findings included: 1. Resident # 1 was admitted to the facility on 7/30/19. The resident had multiple diagnoses which in part included osteoporosis, osteoarthritis, spinal stenosis, chronic pain, dementia, hypertension, diabetes, a history of hip replacement surgery, and polyneuropathy. The resident also had a history of vertebrae fracture due to osteoporosis. Resident # 1's quarterly Minimum Data Set assessment, dated 8/5/24, coded the resident as severely cognitively impaired. The resident was also assessed to be totally dependent on staff for hygiene, bathing, and mobility needs. The resident was not assessed to have falls since the last assessment MDS assessment. Review of nursing notes from 8/5/24 to 8/11/24	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 46	F 689		

revealed no falls or accidents.

Review of Resident # 1's care plan, updated on 8/25/24, revealed the staff identified the resident was at risk for fractures due to her osteoporosis. This had been added to the care pan on 1/22/20 and remained part of the resident's active care plan. Staff were directed on the care plan to avoid pushing and pulling on her extremities and to also observe for signs of pain or discomfort. Additionally, staff members were directed on the care plan to use a mechanical lift with full body sling for all transfers. This intervention had added to the care plan on 4/5/20 and remained part of the resident's active care plan.

On 8/2/24 at 3:14 PM Nurse # 7 documented the following information in a nursing entry. The resident was having some pain in her left knee. The knee was noted to have a "little swelling." The Nurse Practitioner was notified and ordered the resident to have an ice pack as needed and an x-ray of the left knee. A family member was contacted at that time who was agreeable to the orders.

Review of the x-ray report, dated 8/2/24, revealed the following information. The resident had "marked degenerative spurring." The bones appeared "diffusely demineralized" with "marked osteoarthritis." There was an old fracture of the tibia and fibula noted, but no acute fracture or dislocation was seen.

On 8/7/24 the Nurse Practitioner (NP) saw the resident and documented the following information. The resident was having increased knee pain. The 8/2/24 x-ray had shown osteoarthritis and no acute fracture. The resident

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was calm, relaxed, and appeared comfortable. She was able to say she had left knee pain but was not able to say if she had bumped her knee or what had occurred. The NP noted the resident's pain appeared to be a worsening chronic pain and she was already receiving pain medication. The NP further noted she would order a topical analgesic cream to be applied four times per day.

NA # 6 was interviewed on 9/25/24 at 5:00 PM and reported the following information. Prior to Resident # 1 being found with a fracture she and another Nurse Aide would stand and pivot the resident to bed. She (NA # 6) would work on second shift and there would be no lift pad underneath the resident when they came in. She did not understand how the other Nurse Aides were using a lift either if there had been no lift pad underneath her. Therefore, they lifted her in bed when they would find no lift pad beneath her. She (NA # 6) was not aware of any particular incident or transfer that had caused injury to the resident's leg. She had not complained after any specific transfer of more pain than usual.

On 8/11/24 at 10:12 AM a telehealth visit was conducted for Resident # 1's complaint of "pain all over." The provider noted the following information. The resident was seen for generalized pain and "not acting herself." While on the telehealth call, the provider ordered a COVID test which was done and showed a positive result. At the time of the telehealth assessment, the resident repeated "pain" to the provider and that she "need hospital." The provider further noted the resident would be sent to the hospital per her request for evaluation.

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A review of hospital emergency department records revealed an x-ray was completed for a second time on 8/11/24 while the resident was being evaluated at the hospital. This x-ray showed the resident had an acute fracture of the left distal femur involving the metaphysis with mild impaction and no displacement. There was also chronic deformity of the lateral tibial plateau suggesting a chronic healed fracture. There was also a chronic healed fracture of the proximal fibula. There was moderate to marked medial and lateral compartment osteoarthritis and osteopenia. (The distal femur, which was where the fracture was located, is right above the knee.)

On 8/11/24 the resident returned to the facility without admission to the hospital.

According to orthopedic records following the identification of the fracture, the resident was to wear a splint for immobilization to the knee.

On 8/11/24 at 8:37 PM Physician # 2 documented the following note. "Chart reviewed. Resident was complaining of left knee pain on 8/2. No h/o (history of) trauma. X-ray was obtained at that time which showed osteoarthritis with no acute fracture. Today was seen in ED with left distal femur fracture on x-ray, but also noted osteopenia, bone demineralization. Resident has h/o (history of) osteoporosis, on Alendronate. Resident has also been on pain medication throughout. Probable that fracture was of low energy 'pathological' type, given lack of trauma. It is also likely that resident had a hairline fracture that x-ray of 8/2/24 did not pick up, but became pronounced over the course of the week and was now apparent on x-ray from today." (Alendronate is a medication used to treat osteoporosis).

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Resident # 1's Responsible Party (RP) was interviewed on 9/24/24 at 1:10 PM and reported the following information. The resident had some swelling in her knee near the end of July and near the first of August. She underwent an x-ray of her knee at the facility, but even prior to that date the resident seemed to be having more pain and problems with her knee than usual. The RP could not recall an exact date that the change was noted. When the x-ray came back negative on 8/2/24, she continued to have problems. The resident was seen in the hospital ED (emergency department) because she was not "acting right" on 8/11/24. At that time, he (the RP) asked the hospital staff to also x-ray the resident's knee. The hospital x-ray showed the knee fracture. He was under the impression that the staff had been using a mechanical lift to transfer the resident, and he did not know how she could have broken her leg.

The rehab director was interviewed on 9/26/24 at 10:30 AM and reported the following information. Resident #1 had been evaluated by the rehab department for the mode of transfer staff were to use for transfers. Prior to Resident # 1's fracture being identified the resident had been deemed to need a mechanical lift for safe transfers. It had not been safe to transfer her by standing and pivoting. She had brittle bones. Also, in order to use a sit to stand mechanical lift, a resident was required to be able to support a certain percentage of their weight or that type of lift would put too much pressure on their legs. Resident # 1 was not able to use the sit to stand mechanical lift either. For safety reasons, the staff were to use the total mechanical lift.

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The facility's medical director was interviewed on 9/25/24 at 5:10 PM and reported the following information. Resident # 1 had bone density problems in addition to advanced age. Due to the extent of her bone fragility and advanced age, the fracture she had sustained could have happened if the staff had been using a mechanical lift, turning and positioning her, and doing everything correctly. Her osteoporosis placed her at greater risk for the injury. Just because staff at times had transferred her by standing and pivoting her, did not indicate that the fracture occurred during that particular type of transfer.

2. Resident # 2 resided at the facility from 11/30/16 until her final discharge on 9/4/24. The resident in part had diagnoses which included stroke, atherosclerotic heart disease, osteoporosis, dementia with behavioral disturbance, contracture of the left and right leg, history of hallucinations, and anxiety.

Resident # 2's quarterly MDS (Minimum Data Set) assessment, dated 8/16/24, coded the resident as rarely/never understood and unable to complete an interview for cognition. The resident was coded as being totally dependent on staff for bathing, dressing, and hygiene needs. The resident was also coded as needing total staff assistance to turn in bed, go from a sitting to lying position, and for transfers. Since the last MDS assessment, the resident was not coded as having falls.

Review of Resident # 2's care plan, dated 8/30/24 revealed staff had identified the resident was at risk for falls. This had been added to the care plan on 9/13/19 and remained as part of the resident's active care plan up until her discharge

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date. One of the care plan interventions directed that the resident was to have fall mats to both sides of her bed. This showed on the care plan as "initiated on 5/20/24" and remained part of the resident's active care plan up until time of discharge.

Review of Resident # 2's record revealed a SBAR (situation, background, appearance, and review) progress note form completed by Nurse # 8 on 9/4/24 at 7:07 AM. The situation was noted to be a fall on 9/4/24. There was not a specific time of the fall. The nurse documented, "Upon hearing a loud noise like a fall, the CNA found the resident on the floor at her bedside. Resident was assessed and assisted back to bed. Resident had a large bump on her forehead and a skin tear on both right and left leg." Nurse # 8 further noted the resident's vital signs were as follows: blood pressure 117/63, pulse 76, respirations 18, and temperature 97.4. Nurse # 4 documented the provider was notified on 9/4/24 at 6:05 AM with orders to send the resident to the ER (emergency room).

NA # 7 had cared for Resident # 2 on the shift which began at 11:00 PM on 9//3/24 and which ended at 7:00 AM on 9/4/24. NA # 7 was interviewed on 9/24/24 at 3:22 PM and reported the following information. Prior to the resident falling she had provided care to the resident around 3:00 AM when she changed her brief. She left the resident on her back in the middle of the bed in a safe position. She had been assigned to the resident "a few times before" the night of the fall. It had been her experience that the resident could use her upper body some. She had never seen any fall mats in the resident's room, and there were no fall mats in place at the time of the

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fall. The resident had resided in a room where she was close to the air and heating unit. Around 5:30 AM she was making rounds and found the resident on the floor. The resident was on the floor near the air and heating unit. Her head was in a pool of blood. There were two skin tears to her legs which appeared to not be new but had reopened. NA # 7 was interviewed regarding anything she had seen that might have contributed to the fall or injuries. NA # 7 reported the resident could move her arms from side to side and forwards and backwards. At times when care was being provided, the resident would make "baby swats" at the staff members. The NA thought the resident had moved her whole body somehow out of bed when she moved her upper body. At the time, she could not find another staff member to help her. Therefore, she picked Resident # 2 up from the floor and put her in the bed. About 20 minutes later, Medication Aide (MA) # 1 came into the room and got Nurse # 8.

MA # 1 was interviewed on 9/24/24 at 4:45 PM and reported the following information. She had been assigned to Resident # 2 when the resident had sustained a fall. She had walked into the room to administer medications to Resident # 2's roommate. At the time, the curtain was partially closed and she (MA # 1) could only see Resident # 2's legs when she entered the room. She could see blood on the resident's leg. She walked completely around the curtain to Resident # 2's side of the room. She (MA # 1) also saw a towel with blood on it and the resident had a head injury. NA # 7 reported, "I found her like this." She (MA # 1) did not ask NA # 7 if she found the resident in the bed or on the floor. When she saw blood, she knew it was beyond her scope of practice and she went to get the Nurse (Nurse

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#8) who was covering for her. Nurse # 8 called 911 and bandaged Resident # 2's head so that it would not bleed further. MA # 1 was interviewed about any factors which might have contributed to the fall and injury. MA # 1 further reported the following information. Earlier in the night the resident had been okay, but she did have confusion. The resident had been talking about going to get something. The resident also had the ability to move side to side some. It had been her (MA # 1's) experience that sometimes dementia residents could do things which were unexpected. The side on which she fell had the heating and air unit by the bed. On the unit there was additional plexiglass installed to vent the air. MA # 1 reported that if she had hit the plexiglass during the fall, it would also have hurt her.

Review of a written statement by MA # 1, which was part of the facility's investigation into the fall and which was dated 9/5/24, revealed in part the following information. As they were preparing Resident # 2 for transport to the hospital following the fall, Resident # 2 "continued talking about going somewhere, walking, seeing specific people (calling them by name.)"

Nurse # 8 was the nurse covering for MA # 1 on the night from 7:00 PM to 7:00 AM. Nurse # 8 was interviewed on 9/24/24 at 8:20 PM and reported the following information. MA # 1 had asked her to check Resident # 2 on the date of the incident. When she entered the room, she asked NA # 7 what had happened, and NA # 7 said she found the resident on the floor. NA # 7 had also placed the resident back in bed. She (Nurse # 8) had last seen the resident around 2:00 AM and she was in bed and okay. The resident would "wiggle slightly" and they tried to

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keep her in the center of the bed. At the time of her (Nurse #8's) assessment, the resident had a little blood on her forehead and an open skin tear to her right and left leg. She (Nurse #8) applied dressings, obtained vitals, and sent the resident to the hospital. She did not recall seeing a floor mat in place where NA # 7 had reported the resident had fallen.

Review of hospital ER records, dated 9/4/24, revealed the following documentation. The resident was "presenting from her nursing facility after fall. Patient is hemodyamically stable and nontoxic-appearing on arrival. She has significant trauma to the face including significant ecchymosis and periorbital ecchymosis and abrasions of the right foot and we will x-ray those was well." Following testing on 9/4/24, the ER physician noted the following information. "Patient's lab work and CT imaging showed no traumatic injuries other than a nasal bone fracture. Patient will be given ENT (ears, nose, throat) follow up. She does have significant brusing and edema of the face. Steri-strips were placed over a skin abrasion on the forehead. Patient otherwise remained at baseline." According to the hospital record, Resident # 2 was discharged to another facility.

On 9/4/24 the Nurse Practitioner made a progress note documenting the following information. According to the nursing notes the resident had fallen out of bed and sustained a large bump to her head and a skin tear to both her right and left leg. The resident had been evaluated at the hospital and the family had requested that the resident to be transferred to another facility in order to be closer to the family.

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Resident # 2's family member was interviewed on 9/24/24 at 12:10 PM and reported the following information. He visited about twice per week. He did not understand how the resident had fallen because her legs "were crossed" and she could not turn herself in bed.

The DON (Director of Nursing) was interviewed on 9/24/24 at 2:50 PM and reported the following information. Although the resident had not had falls since her last MDS assessment, she had fallen earlier in the current year and the staff were to follow her care plan to prevent falls. The resident could move the top part of her body some. The resident had been found earlier in the year with her top part of her body partially hanging down from the bed onto the floor mat. Her lower body had still been in the bed at the time. The facility had investigated the incident which had occurred on 9/4/24. NA # 7 had reported that she had found the resident on the floor during last rounds. According to the DON, there was no witness to say how the fall had actually occurred. The facilty had done a plan of correction following the incident.

The Administrator was interviewed on 9/25/24 at 2:25 PM and reported the following information. They had investigated Resident # 2's fall following the accident and injury. He spoke to NA # 7 and asked her to be honest, and if she had accidentally turned the resident out of bed while providing care, then he encouraged her to say so. NA # 7 had remained consistent in her interviews that she had found the resident on the floor. Resident # 2 resided with a resident who was cognitively impaired and could not report any information related to the circumstances of Resident # 2.

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The Nurse Practitioner was interviewed on 9/25/24 at 9:22 AM and reported the following information. She had often seen Resident # 2. She personally had witnessed the resident to have the capability to move some although she had contractures. The resident was very stiff. When the head of the bed was left up at any given angle, the resident at times would push her upper body back against the bed. Due to stiffness, her body did not completely conform to the bed mattress if the head of the bed was elevated. As she moved her upper body, her body would angle itself in the bed. She could become twisted in the bed and she (the NP) had witnessed this herself.

A review of the facility's investigative files regarding Resident # 2's fall and injuries included a statement from the former Medical Director (Physician # 2). Physician # 2 wrote he had reviewed the resident's medical record and some photographs of her injuries. The physician further wrote, " I see no evidence of direct trauma to the resident's face other than to her forehead. As I understand , she also sustained a nasal fracture. The ecchymosis surrounding her eyes extending down to her face and neck is likely due to 'tracking' or bleeding from the original trauma (in this case her forehead) which flows subcutaneously via gravity to the rest of her face. This should fully resolve over time." The physician further wrote, "The resident has a history of falls with serious injuries and a history of osteoporosis. It was reported that she fell out of bed, an event that was unavoidable, and sustained the trauma then."

Resident # 2's physician, who served as the

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facility's current medical director, also had submitted a note in regards to the resident's fall during the investigation. The physician noted Resident # 2 had a history of neurocognitive disorder secondary to Alzheimer's dementia with a history of behavioral disturbance, hallucinations, depression, and anxiety. The Medical Director further wrote, "This resident historically has had history of fall from bed level with episode of agitation and disorientation. Reports in the past have indicated the resident intermittently gets aggressive with staff during patient care. A history of Alzheimer's dementia with major neurocognitive disorder associated with behavioral disturbance certainly increases risk of agitation, confusion, disorientation, disruptive behavior, falls and injuries in this patient population. In addition, specifically with underlying bone density disorder such as osteopenia, osteoporosis, general frailty related to advanced age, this patient population are significantly prone to major injuries with minor trauma and ground level fall." The physician further wrote, "This resident of note is non ambulatory at baseline due to contractures of the lower extremities with muscle atrophy however these factors historically had not precluded falls from bed in these patient populations."

The facility's Medical Director was interviewed on 9/25/24 at 5:10 PM and reported the following information. It would be difficult to say how exactly Resident # 2 had fallen. From his personal experience, he knew there were paraplegics and residents with contractures who had slid out of bed. This had historically occurred on multiple occasions. Just because a resident was unable to move their lower body and/or had contractures did not indicate they were not at risk

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for falling out of bed. He had reviewed Resident # 2's injuries she sustained from 9/4/24 and the injuries were consistent with a fall.

The DON was further interviewed on 9/26/24 at 1:00 PM and reported the following information. Following Resident # 1's injury the facility had completed an investigation and assessed residents on the Unit where Resident # 1 resided to determine if there were any other injuries. They had also completed inservice training about transfers and conducted competency checks. Following Resident # 2's fall, they also did an investigation and another plan of correction. Their corporate office was involved after Resident # 2 fell. The facility initiated their own plan of correction and then also incorporated components into their plan of correction as requested by their corporate office. According to the DON, the combined plan of correction addressed all factors to ensure residents were safely transferred by their plan of care and that staff were following care plans to prevent accidents.

The DON provided the plan of correction:

Corrective Action for affected residents

Resident #1 was sent to the ER for evaluation and treatment as indicated due to complaint of pain to left knee on 8/11/24. Resident had x-ray of left knee 1 or 2 views, which revealed the following conclusion; "Marked osteoarthritis of the left knee. No definite acute fracture."
XR Knee 3 views Left, was obtained during ER visit at the hospital, which revealed the following: Findings: Marked regional osteopenia. Lower thigh subcutaneous edema and soft tissue

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swelling. There is an acute distal femoral fracture involving the metaphysis, with mild impaction laterally but no significant displacement or angulation. During residents' investigative review, interviews of staff were conducted by Director of Nursing (DON), as well as review of resident record. Upon review of resident record, there were no trauma and/or accident identified prior to resident having swelling or identification of fracture. 8/11/24, resident record was reviewed by attending physician, which revealed, "Probable that fracture was of low energy "pathologic" type, given lack of trauma."
During investigative interview with nursing staff, it was revealed that an NA transferred resident from wheelchair to bed via stand pivot. Resident's care plan reflects the transfer status as a mechanical lift.
Since 8/11/24, staff have been following resident plan of care and transferring resident by mechanical lift.
Resident #2 sustained a fall with injury on 09/04/24 while residing in the facility. Resident transferred to the hospital for evaluation and treatment as indicated. Upon review of resident medical record obtained from the hospital, resident had a CT of Facial Bones WO Contrast completed. Per image impression, it is noted; "Questionable left nasal bone non-displaced fracture."
Resident no longer resides at this facility.
It was noted during facility investigation, that bilateral fall mats were not in place at time of fall per resident's care plan, due to history of falls.
Others having the potential to be affected
All residents have the potential to affected.
Skin checks completed on residents located on the 100/200 halls of the facility by the Nurse Administrative Team on residents who are not

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alert and oriented with a BIMS of less than 12.
Skin checks completed and reviewed by Director of Nursing (DON) on 8/16/24.
Pain assessments completed on residents located on the 100/200 halls of the facility by the Nurse Administrative Team. Residents who rated their pain 7-10 on a scale of 0-10, with 10 being the highest level, were communicated with the facility Nurse Practitioner. Pain assessments reviewed by Director of Nursing (DON). All assessments completed by 8/16/24.

A whole house audit was completed by the DON to ensure fall mats were in place per resident plan of care, as related to fall interventions on 9/4/24.
An audit was initiated by the DON and/or designee on 9/18/24 of falls for the past 30 days to ensure that facility policy "NSG215 Falls Management" was followed properly with visual observation/validation of the fall interventions according to the residents plan of care are in place to include fall mats as applicable, as well as mode of transfer being followed per resident plan of care. Audit completed 9/23/24.
100% audit of Fall Risk Evaluations completed by DON and/or designee to ensure each resident currently residing in the facility has an updated evaluation completed with the residents plan of care reviewed to ensure proper interventions are in place to potentially prevent falls. Audits completed 9/23/24.

What measures will be put in place or what systemic changes
Education provided to all licensed/certified nursing staff to include; RN/LPN/CMA/CNA, on facility policies; NSG234 Safe Resident Handling/Transfer Equipment which included competency check offs and OPS300 Abuse

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Prohibition by the Nurse Practice Educator (NPE) and/or designee to be completed by 8/16/24. No licensed and/or certified nursing staff shall be permitted to work until education has been received.
Education provided to all licensed/certified nursing staff to include; RN/LPN/CMA/CNA, on facility policies; NSG215 Falls Management, NSG234 Safe Resident Handling/Transfer Equipment as relates to falls management, and OPS100 Accidents/Incidents by the Nurse Practice Educator (NPE) and/or designee to be completed by 9/23/24.
No licensed and/or certified nursing staff shall be permitted to work until education has been received.
Monitoring of Corrective action
Facility administration met with the corporate office on 9/18/24 and reviewed their action plan which included the quality assurance monitoring with plans made to move forward.
DON and/or designee will audit 5 random transfers daily x2 weeks (starting 8/19/24), then 5 random transfers bi-weekly x2 weeks, then 10 random transfers per month x1 month, to ensure that transfers are being executed properly per resident transfer status as care planned.
DON and/or designee will audit falls daily x4 weeks (starting 9/23/24), then 5x/week (Monday - Friday) x2 months to ensure that facility policy NSG215 Falls Management has been initiated and properly executed to ensure facility policy/protocol was followed as indicated, to include ensuring resident fall interventions are in place as resident's care plan reflects.
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

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F 689	Continued From page 62 Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Director of Nursing will be responsible for implementation of the plan. Date of Compliance: 09/23/24. The facility's plan of correction was validated by the following: Beginning on 9/24/24 at 9:05 AM a tour of the facility was conducted. Multiple residents were interviewed and the interviews did not reveal a lack of supervision to prevent accidents. There were no residents observed with extensive injuries which might signify traumatic accidents. Beds were observed to be in the low positions for unattended residents and staff were supervising residents. Multiple staff members were interviewed and reported they utilized a total mechanical lift to transfer Resident # 1. Staff also reported they had received inservice education about fall prevention as outlined by the facility in their plan of correction, and were knowledgeable they were to follow the plan of care for residents. The facility presented evidence of audits and inservice training per their plan of correction. The facility's compliance date of 9/23/24 was validated on 9/26/24.	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		10/15/24

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F 725	Continued From page 63 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff the facility failed to provide sufficient staff to ensure a resident (Resident # 2) received an assessment prior to being moved following a fall with a head injury. This was for one of two residents identified not to receive medical services on the night shift which began on 9/3/24 at 11:00 PM. The findings included: Resident # 2 resided at the facility from 11/30/16 until her final discharge on 9/4/24. The resident had diagnoses which included stroke, atherosclerotic heart disease, osteoporosis,	F 725	1. Nursing Home Administrator, Director of Nursing, and/or designee reviewed and revised the Facility Assessment to identify and implement staffing needs for each unit to ensure appropriate staffing levels to meet the needs of residents on 10/11/2024. Resident #13 was discharged on 09/04/2024 and no longer resides at the facility. 2. Beginning on 10/15/2024, the on-call Administrative Nurse will monitor call-ins after hours to ensure sufficient nursing	

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F 725	Continued From page 64 dementia with behavioral disturbance, contracture of the left and right leg, history of hallucinations, and anxiety. Resident # 2's quarterly MDS (Minimum Data Set) assessment, dated 8/16/24, coded the resident as rarely/never understood and unable to complete an interview for cognition. NA # 7 was one of the Nurse Aides working on Station 1 and had cared for Resident # 2 on the shift which began at 11:00 PM on 9/3/24 and which ended at 7:00 AM on 9/4/24. NA # 7 was interviewed on 9/24/24 at 3:22 PM and reported the following information. Around 5:30 AM she was making rounds and found the resident on the floor. The resident was on the floor near the air and heating unit. Her head was in a pool of blood. There were two skin tears to her legs which appeared to not be new but had reopened. There were only five Nurse Aides in the facility that night. NA # 7 looked and could find no one to help her with the resident when she initially found her. She did not want to leave the resident lying there. She therefore picked the resident up and placed her back in the bed. She was with her for about 20 minutes when MA (medication aide) # 1 came in the room. MA # 1 was interviewed on 9/24/24 at 4:45 PM and reported the following information. She had been assigned to Resident # 2 when the resident had sustained a fall. She had walked into the room to administer medications to Resident # 2's roommate and had found NA # 7 caring for Resident # 2. The resident had blood on her and was already back in bed. Prior to the incident, MA # 1 had been busy giving medications that night and had been in another resident's room.	F 725	coverage. The on-call Administrative Nurse will be provided a telephone roster of nursing employees, to include contracted nursing employees and will be responsible for finding coverage for shift (s). The on-call Administrative Nurse will also notify the Director of Nursing and/or Administrator of staffing levels to ensure on-going sufficient nursing staff. An Ad hoc Quality Assurance Performance Improvement Meeting will be held on 10/14/2024 to present the plan of correction for the deficient practice. 3. The Nursing Home Administrator and/or designee will re-educate the Director of Nursing, Scheduling Coordinator, and Licensed Nurses on ensuring sufficient staffing levels to meet the needs of the residents by 10/11/2024. 4. Beginning 10/06/2024, the Nursing Home Administrator and/or designee will review staffing schedules to ensure sufficient staffing to meet the needs of residents 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks. The Nursing Home Administrator and/or designee will review the results of the quality monitoring (audits) in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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F 725	Continued From page 65 Review of Resident # 2's record revealed a SBAR (situation, background, appearance, and review) progress note form completed by Nurse # 8 on 9/4/24 at 7:07 AM. The situation was noted to be a fall on 9/4/24. There was not a specific time of the fall. The nurse documented, "Upon hearing a loud noise like a fall, the [Nurse Aide] found the resident on the floor at her bedside. Resident was assessed and assisted back to bed. Resident had a large bump on her forehead and a skin tear on both right and left leg." Nurse # 8 documented the provider was notified on 9/4/24 at 6:05 AM with orders to send the resident to the ER (emergency room). Nurse # 8 was the nurse covering for Medication Aide (MA) # 1 on the night from 7:00 PM to 7:00 AM. Nurse # 8 was interviewed on 9/24/24 at 8:20 PM and reported the following information. She thought she may have been busy in a room when the resident had fallen. MA # 1 had asked her to check Resident # 2 on the date of the incident. When she entered the room, she asked NA # 7 what had happened, and NA # 7 said she found the resident on the floor. NA # 7 had also reported she had placed the resident back in bed. During further interviews with Nurse # 8 on 9/27/24 at 9:44 AM and again on 10/3/24 at 2:42 PM the nurse reported the following information. It had been a busy night that night. She also had a resident who had what she referred to as a "death rash" and for whom she was responsible. She was the only licensed nurse on Station 1. When there were only two nurse aides on Station 1 at night she tried to answer call lights as well as give her medications, do her assessments, and cover for the medication aide. When call outs	F 725	5. Date of Compliance: 10/15/2024	

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occurred, the nurses that were on duty tried to call and get staff to come to work while they were also responsible for doing their job duties. She did think if there had been more staff it might have made a difference in her being available for Resident # 2. According to Nurse # 8 that would have given more ears and eyes on the unit to see and hear what was going on. The Station was a long hall and if you were on one end, it was a long way to the other end where things might be happening. She did not know exactly how many residents each Nurse Aide had or what the census was that night.

Review of hospital ER records, dated 9/4/24, revealed the following documentation. The resident had significant trauma to the face including significant ecchymosis and periorbital ecchymosis and abrasions of the right foot and we will x-ray those was well." Following testing on 9/4/24, the ER physician noted the following information. "Patient's lab work and [computed tomography] imaging showed no traumatic injuries other than a nasal bone fracture."

Review of staffing sheets for the night shift which began on 9/3/24 at 11:00 PM revealed there were seven Nurse Aides who had been scheduled to work and two Nurse Aides had called out, thereby leaving five Nurse Aides for the entire facility. A review of staffing sheets revealed there were two Nurse Aides (NAs) assigned to Station # 1 where Resident # 2 resided, a Nurse, and a Medication Aide. (Resident # 2 had resided on Station # 1).

NA # 9 was the other Nurse Aide assigned to Station 1 on the 11:00 PM to 7:00 AM shift which began on 9/3/23. NA # 9 was interviewed on 9/25/24 at 9:19 AM and reported the following

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information. She had been busy with her own residents during the night Resident # 2 fell. She did not know what had occurred. She was in a room.

According to the facility's schedule, the night shift nursing supervisor (Nurse # 3) had an assignment on the night of 9/3/24. Nurse #3 was interviewed on 9/25/2024 at 7:28 AM and provided the following information. Nurse #3 explained she was the nursing supervisor for the night shift that began at 11:00 PM on 9/3/2024 and ended at 7:00 AM on 9/4/2024. Nurse #3 was also serving as the nurse for station 3 on the medication cart. She had started to work at 7:00 PM as a floor nurse before also assuming responsibility as facility supervisor at 11:00 PM. Nurse #3 explained she was passing out medications and assisting the one nurse aide for the hallway monitor residents. Nurse #3 further explained she had a resident who fell at approximately 9:30 PM and needed to be continuously monitored until she was ultimately sent to the hospital at approximately 11:00 PM. Nurse #3 stated she had paperwork to complete for the resident who fell as well as additional charting to do for the other residents. Nurse #3 stated it was hard to recall the specific times and events of the evening of 9/3/2024 going into the morning of 9/4/2024 because she was so busy. Nurse #3 knew the facility had 5 nurse aides after 11:00 PM on 9/3/2024 and she did the best she could to take care of her assigned residents. Nurse #3 did recall that Resident #2 also had a fall in the morning of 9/4/2024 but could only say she saw her after EMS arrived to transport her.

On 10/3/24 at 11:31 AM an interview was held with a new Administrator (Administrator # 2) and

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F 725	Continued From page 68 a new interim DON (Director of Nursing) DON # 2 as of the date of 10/3/24. According to these new administrative staff members, the staff member who was responsible for making out the schedule and staffing was not available for interview.	F 725		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(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(h)(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;	F 842		10/15/24

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F 842	Continued From page 69 (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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(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 nurse practitioner and staff interview, the facility failed to accurately document health status information in the medical record for two (Resident #3 and Resident #13) of	F 842	1. Resident #13 was discharged on 09/04/2024. Resident #3 was discharged on 09/06/2024 and no longer resides at the facility.	

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F 842	Continued From page 70 three residents reviewed for accuracy of the medical record. Findings included: 1. Resident #3 was admitted on 8/27/2024. Documentation in a hospital transfer form dated 9/6/2024 revealed Resident #3 was transferred to the hospital at 8:30 AM at the request of the responsible party. Documentation in a Nursing Advanced Skilled Nursing Evaluation dated 9/6/2024 at 2:43 PM written by Nurse #11 revealed Resident #3 had a temperature of 98.0 degrees Fahrenheit at 2:44 PM on her forehead, blood pressure of 100 systolic/72 diastolic at 2:44 PM, and pulse of 76 beats per minute taken at 2:44 PM. The same skilled evaluation revealed documentation of pain, neurologic, mood, behavior, cardiovascular, gastrointestinal, nutrition, and skin condition of Resident #3. Resident #3 did not return to the facility and was not at the facility on 9/6/2024 at 2:44 PM. Documentation in a general progress note dated 9/6/2024 at 3:43 PM revealed a follow-up phone call to the hospital was made and Resident #3 was admitted for acute kidney injury and septic shock. Nurse #11 was interviewed on 10/3/2024 at 9:10 AM. Nurse #11 revealed she was a travel nurse whose contract ended with the facility. Nurse #11 stated she did not recall Resident #3 as she was rotated around to various units in the facility when she worked there. Nurse #11 stated if the documentation she wrote was after the resident left for the hospital, then it was documentation	F 842	2. The facility determined that all residents have the potential to be affected. An Ad hoc Quality Assurance Performance Improvement Meeting will be held on 10/14/2024 to present the plan of correction for the deficient practice. 3. The Nurse Practice Educator and/or designee will educate Licensed Nurses by 10/11/2024 on the accuracy of resident records with emphasis on documentation of medical services and accurate documentation related to discontinuation of orders, vital signs, documentation post discharge. New Licensed Nurses will be educated by the Nurse Practice Educator and/or designee during the orientation process. The Director of Nursing and/or designee will review discharges during clinical meetings to ensure accuracy of the resident record. 4. The Director of Nursing and/or designee will conduct random quality reviews of 5 random residents to ensure no documentation post discharge and catheter documentation and skin documentation are accurate on skilled evaluation 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks. The Director of Nursing and/or designee will review the results of the quality monitoring (audits) in the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting for one quarter to ensure compliance is achieved	

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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
F 842	Continued From page 71 she made in error. An interview was conducted with Nurse Practitioner (NP) #1 on 9/25/2024 at 8:48 AM. NP #1 revealed she reviewed the record of Resident #3. NP #1 stated she relied on the documentation the nurses provided in the medical record and that the nursing documentation should accurately represent the status of the resident in the medical record. 2. Resident # 13 was admitted to the facility on 8/5/24. On 8/30/24 at 5:44 PM Nurse # 4 documented Resident # 13 was complaining of his catheter feeling weird during the shift of 7AM to 7PM. He had been found to have some swelling in his groin which he reported had happened before. The catheter was deflated and removed, and the resident refused to have the catheter reinserted. He was voiding in a urinal. The physician had been contacted and reported to monitor the resident and send him out if he had pain or problems voiding. A review of the record revealed the catheter was never reinserted prior to the resident's discharge on 9/4/24. The order remained in the resident's electronic medical record for him to have a catheter. Nurse # 5 had cared for Residednt # 13 on 9/3/24 from 7:00 AM to 7:00 PM. Nurse # 5 was interviewed on 9/26/24 at 1:40 M and again on 9/30/24 at 12:15 PM. Nurse # 5 reported the resident had been voiding and going to the bathroom on 9/3/24. He no longer had a catheter.	F 842	and sustained. Subsequent plans of correction will be implemented as necessary. 5. Date of Compliance: 10/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

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F 842	Continued From page 72	F 842		

Nurse # 8 had cared for Resident # 13 from 7 PM on 9/3/24 until 7:00 AM on 9/4/24. Nurse # 8 was interviewed on 9/27/24 at 9:44 AM and reported the following information about caring for Resident # 13 on her shift. The resident had a rash on her shift which Nurse # 8 referred to as a "death rash" while being interviewed by the surveyor. The rash was ciruclar and showed up as redness on his skin. It appeared on his legs and his stomach.

On 9/4/24 at 2:39 AM Nurse # 8 documented "a skilled evalution" which was incomplete in that it did not mention any type of rash Nurse # 8 reported the resident had. It was also inaccurate in that it noted the resident had a catheter which he did not have.

The Nurse Practitioner (NP) was interviewed on 10/2/24 at 3:52 PM. During this time the NP was interviewed about the accuracy of Resident # 13's record as it related to his condition. The NP reported she referenced the nursing notes when evaluating residents and complete information was helpful to have.