STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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E 000	Initial Comments The survey team entered the facility on 11/04/24 to conduct a recertification survey and complaint investigation. The survey team was onsite 11/04/24 through 11/07/24. Additional information was obtained offsite on 11/08/24. Therefore, the exit date was 11/08/24. The facility was in compliance with the requirement at CFR 483.73, Emergency Preparedness. Event ID# 5WFB11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 11/4/24 to conduct a recertification and complaint investigation. The survey team was onsite from 11/4/24 through 11/7/24. Additonal information was obtained on 11/8/24. Therefore the exit date was 11/8/24. Event ID# 5WFB11. The following intakes were investigated NC00212058, NC00213126, NC00213463, NC00214597, NC00214933, NC00215557, NC00216555, NC00217020, NC00219354, NC00218063, NC00219017, NC00219101, NC00220234, NC00220269, NC00220481, NC00220832, NC00220976, NC00221063, NC00221246, NC00221291, NC00221328, NC00221401, NC00222809, NC00223258, NC00223608, and NC00223699. 6 of 93 complaints allegations resulted in a deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group,	F 565		12/10/24

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

Electronically Signed | 12/06/2024

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F 565	Continued From page 1 to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews the facility failed to provide resolution of Resident Council Meeting grievances for 5 of 6 monthly Resident Council Meetings. The Resident Council had repeated concerns regarding coffee not being served before breakfast and clothes not coming back from laundry (5/28/24, 06/25/24, 07/30/24, 08/27/24,	F 565	Residents residing in the facility have the potential to be affected by the deficient practice. The Social Worker reviewed the resident council minutes for the last 60 days. Grievances that were identified in the review were placed on the appropriate form and worked with a goal of resolution.	

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F 565	Continued From page 2 and 09/24/24). On 05/28/24 the Resident Council Meeting Minutes noted a dietary concern that coffee was not being served or made before breakfast. The Resident Council Follow-Up form attached to the 05/28/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 06/25/24 the Resident Council Meeting Minutes noted a dietary concern that coffee was not being served or made before breakfast. The Resident Council Follow-Up form attached to the 06/25/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 07/30/24 the Resident Council Meeting Minutes noted a housekeeping concern that clothes were not being returned from laundry. The Resident Council Follow-Up form attached to the 07/30/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 08/27/24 the Resident Council Meeting Minutes noted a housekeeping concern that clothes were not being returned from laundry. The Resident Council Follow-Up form attached to the 08/27/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 09/27/24 the Resident Council Meeting	F 565	The Activities Director received education from the Regional Nurse Consultant regarding taking the concerns from resident council and writing them up on grievance forms. The forms are then to be given to the Administrator or Social Worker for completion. Newly hired social worker(s) will receive the education during orientation from the Administrator. The Administrator or designee will audit resident council minutes monthly for three months to ensure concerns are being written as grievances and the process worked. The Administrator will be responsible for forwarding the results to the QAPI Committee monthly for 3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 565	Continued From page 3	F 565		

Minutes noted a housekeeping concern that clothes were not being returned from laundry.

The Resident Council Follow-Up form attached to the 09/27/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council.

Interviews conducted with Resident #15, Resident #16, Resident #17, Resident #62, Resident #63, and Resident #66 during the Resident Council Meeting on 11/06/24 at 1:30 PM revealed there had been no resolution with the ongoing concerns of coffee not being prepared before breakfast and clothes not being returned from the laundry. The residents further the issues were still a concern.

Interview conducted with the Activity Director (AD) on 11/06/24 at 1:45 PM revealed she became the AD in May 2024 and was not aware grievances had to be completed to address concerns voiced during Resident Council. The AD further revealed she addressed concerns during stand-up meetings and with department heads but had no documentation to show that concerns were resolved. The AD stated she was aware issues had been ongoing and had addressed department heads but was unaware of any improvement from issues addressed

Interview conducted with the Administrator on 11/07/24 at 10:00 AM revealed he was not aware grievances were not being completed and resolved from Resident Council meetings. The Administrator further revealed he expected concerns to be addressed and followed up on and documentation to be included within the Resident Council minutes.

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F 575	Continued From page 4	F 575		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. This observation occurred for 4 of the 4 days during the onsite recertification survey.	F 575	Required posting were posted on 11/7/2024 by Nursing Home Administrator. Residents residing in the facility have the potential to be affected by the deficient practice. An audit of the facility was performed on 11/7/24 identifying whether the required postings were posted and what was needed. Postings for state and local authorities needed were posted on 11/7/2024.	12/10/24

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F 575	Continued From page 5 The findings included: An observation of the facility's common areas, upper and lower nursing units was completed on 11/04/24 at 11:12 AM. The observation revealed no signage or posting which included name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. On 11/05/24 at 9:15 AM, an observation of the facility's common areas, upper and lower nursing units was completed. The observation revealed no signage or posting which included name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. On 11/06/24 at 2:27 PM, afternoon rounding was conducted of the facility's common areas, upper and lower nursing units. The observation revealed no signage or posting which included name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. A walking tour of the facility (common areas, upper and lower nursing units) was completed on 11/07/24 at 8:30 AM with the Administrator.	F 575	The Administrator was educated on the required postings for state and local authorities on 11/12/2024 by the Regional Director of Operations. Any newly hired Administrators will be educated on the required posting within the facility for state and local authorities by the Regional Director of Operations. The Administrator will audit the required posting for a total of (3) months ensuring state and local authorities are posted within the facility for the residents viewing including but not limited to the name, address and telephone number of the agencies. The Administrator will forward the results of the audit to the QAPI Committee monthly for 3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 575	Continued From page 6 There were no required postings observed throughout the tour except for the local Ombudsman posting. An interview with the Administrator was conducted on 11/07/24 at 8:42 AM. The Administrator stated he was not certain why the postings were not in place. The Administrator verbalized the postings were important and he would have his staff get the postings back in place.	F 575		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		12/10/24

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F 583	Continued From page 7 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interview, and staff interviews, the facility failed to provide privacy for a catheter bag and activities of daily living (ADL) care for 2 of 2 residents (Resident #14 and Resident #55) reviewed for personal privacy. The findings included: 1. Resident #14 was admitted to the facility on 10/07/24 and resided in Room 211with diagnoses which included obstructive uropathy, urinary tract infection, and muscle weakness. The admission Minimum Data Set (MDS) assessment dated 10/14/24 revealed Resident #14 was cognitively intact for decision making and was dependent for toilet use. The MDS further revealed Resident #14 was coded for an indwelling catheter and was incontinent for bowels. An observation and interview conducted with Resident #14 on 11/04/24 at 12:20 PM revealed Resident #14 did not have a privacy curtain near the resident's door which allowed him to be viewed from the hallway. Resident #14 indicated staff did not attempt to block the doorway entrance to provide privacy during care. Resident	F 583	Room #211 and #213 both received privacy curtains on 11/6/24 by the maintenance supervisor. Resident #14 received a catheter bag privacy bag on 11/6/24. Residents who require the use of privacy curtains or foley catheters have the potential to be affected by the deficient practice. An audit was performed on resident rooms ensuring the placement of privacy curtains. An audit was performed of residents with foley catheters to ensure privacy bags were present. This audit was conducted during the week of 11/12/24 through 11/15/2024. Any privacy curtain needed for a resident room identified was resolved with placement. In addition privacy bags were placed if not already present on foley catheters. Staff was educated on the placement/need of privacy cubical curtains as well as privacy bags on foley catheters. This education was provided during the week of 11/12/2024 through 11/15/2024. Newly hired staff will be educated on the privacy of residents with	

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F 583	Continued From page 8 #14 further revealed he had not had a privacy curtain since admission. Resident #14 stated he had expressed to nursing staff that he would like a curtain, but the curtain had not been hung. Resident #14 was lying in bed with his catheter visible from the resident's door. The bag was observed to not have a privacy cover. Resident #14 further revealed since admission his catheter did not have a privacy cover and was frustrated and embarrassed for his urine to show. An observation and interview with Nurse Aide (NA) #8 on 11/05/24 at 10:15 AM revealed Resident #14 had not had a privacy curtain at his doorway since admission. NA #8 indicated she did not recall anyone entering the room during care to expose Resident #14 but had no way to block him from being seen from the hallway if someone did open the door. NA #8 further revealed she had reported to the prior housekeeping director multiple times that curtains had been missing on the 200 Hall. NA #8 stated she was unaware why Resident #14's curtain had not been hung but Resident #14 could be seen from the hallway if someone had opened the door. Another Interview and observation conducted with Nurse Aide (NA) #8 on 11/05/24 at 10:30 AM revealed Resident #14 was in his wheelchair and did not have a privacy cover on his catheter bag. NA #8 further revealed Resident #14 had been upset that he did not have a privacy cover on his catheter. NA #8 indicated she was aware Resident #14 did not have privacy cover since admission and reported it to nursing staff multiple times. An interview and observation conducted with the	F 583	the use of privacy curtains and the use of privacy covers for foley catheters by the Assistant Director of Nursing or Director of Nursing. The Environmental Services Director will audit 10 resident rooms twice a week for twelve weeks to ensure the placement of privacy curtains. The Unit Manager or designee will audit five residents a week for twelve weeks with foley catheters to ensure privacy bags are in place. The Nursing Home Administrator will forward the results of the audits to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 583	Continued From page 9	F 583		

Administrator and the Director of House Keeping on 11/05/24 at 10:45 AM revealed Resident #14 did not have a privacy curtain and expected all residents to have one. The Administrator indicated he was unaware Resident #14 did not have a curtain and expected residents to maintain privacy during care. The Director of House Keeping indicated it was his first day in that role and the Administrator further revealed he was not aware the curtains had not been hung.

Interview conducted with Nurse #4 on 11/05/24 at 11:55 AM revealed Resident #14 did not have a privacy cover on his catheter bag. Resident #14 stated to Nurse #5 that he did not like his urine showing for others to see. Nurse #4 indicated she was aware the resident did not have privacy cover but would get one.

An interview conducted with the Unit Manager (UM) and Director of Nursing (DON) on 11/06/24 at 8:15 AM revealed they were not aware Resident #14 did not have a privacy cover on his catheter bag. DON further revealed she expected all catheters to be covered.

An interview conducted with the Administrator on 11/07/24 at 10:00 AM revealed he was not aware Resident #14 did not have a privacy bag on his catheter. The Administrator further revealed he expected all residents to be treated in a dignified manner and have privacy.

2. Resident #55 was admitted to the facility on 02/11/23 and resided in Room 213.

The annual Minimum Data Set (MDS) assessment dated 09/19/24 revealed Resident #55 was severely cognitively impaired for

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F 583	Continued From page 10 decision making and was dependent for toilet use. The MDS further revealed Resident #55 was always incontinent of bowel and urine. An observation conducted with Resident #55 on 11/04/24 at 12:30 PM revealed Resident #55 did not have a privacy curtain and shared a room with another resident. Resident #55's roommate was severely cognitively impaired and was unable to be interviewed. An observation and interview with Nurse Aide (NA) #8 on 11/5/24 at 10:20 AM revealed Resident #55 had not had a privacy curtain in two to three months. NA #8 further revealed she had reported to the prior housekeeping director multiple times that curtains had been missing on the 200 Hall. NA #8 indicated Resident #55 was incontinent for care and would care for the resident without a curtain between the two residents. NA #8 stated she knew it was an issue that there was no curtain but had reported it to housekeeping multiple times. An interview and observation conducted with the Administrator and the Director of House Keeping on 11/05/24 at 10:45 AM revealed Resident #55 did not have a privacy curtain and expected all residents to have one. The Director of House Keeping indicated it was his first day in that role and the Administrator further revealed he was not aware the curtains had not been hung. The Administrator stated residents were expected to receive privacy.	F 583		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		12/10/24

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F 622	Continued From page 11	F 622		

§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger

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F 622	Continued From page 12 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622		

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F 622	Continued From page 13 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to permit Resident #336 to remain in the facility and initiated the resident's discharge when she returned later than expected from a leave of absence. The resident returned to the facility on 2/12/24 and was informed by staff she was not allowed to remain in the facility due to her being gone from the facility over 24 hours. Additionally, the facility failed to provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 3 residents reviewed for discharge. (Resident 336). The findings included: Resident #336 was initially admitted to the facility on 12/2/23 with diagnoses which included chronic pain, opioid dependence, intentional self-harm by other firearm discharge and anxiety. Review of Resident #336's admission Minimum Data Set (MDS) dated 12/8/23 revealed the resident was cognitively intact and was independent with activities of daily living. Review of a late entry progress note completed by Social Worker #1 on 2/13/24 revealed Resident #336 had been away from the facility for over 24 hours and Social Worker #1 had attempted to contact the emergency contact but was not able to leave a voicemail.	F 622	Resident # 336 no longer resides in the facility. Residents currently residing in the facility have the potential to be affected by the deficient practice. The Social Worker reviewed the discharges for the last 30 days to ensure the discharge was appropriate and if necessary written documentation stating the reason for discharge was provided. Education was provided by the Regional Nurse Consultant to the Social Worker regarding proper discharge and the need for documentation in the medical record concerning the discharge/transfer when a resident□s specific needs cannot be met. This education included that documentation should contain the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). Newly hired social worker(s) will receive the education in orientation from the Administrator. The Administrator or designee will audit two discharged resident records a week for 12 weeks to ensure that the discharge was appropriate and the documentation	

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F 622	Continued From page 14 A review of hospital records revealed Resident #336 was seen in the hospital emergency department on 2/13/24 at approximately 12:15 pm and was accompanied by a family member. The hospital record revealed that Resident #336 had requested her medications to be refilled, was asymptomatic and had no physical complaints. The facility was contacted for a list of her current medications on 2/13/24. Resident #336 was placed in psychiatric observation due to her history of psychiatric behaviors and the need to provide a safe environment. Review of Resident #336's admission Minimum date set (MDS) dated 2/18/24 indicated Resident #336 was readmitted to the facility on 2/15/24 from the hospital. A review of the medical record revealed no documentation that indicated the reason the facility could not meet the resident's needs. An interview was conducted with Social Worker #1 and Billing Office Manager #1 on 11/6/24 at 2:12 pm. Social Worker #1 and Billing Office Manager #1 indicated that Resident #336 returned to the facility from her leave of absence on 2/12/24 at approximately 12:00 pm. They were instructed by the Regional Billing Office Manager to not allow Resident #336 to remain in the facility and to discharge her due to her being gone from the facility over 24 hours, which ended her insurance coverage. Social Worker #1 further revealed that she did not do any discharge planning and did not issue a notice of transfer discharge for Resident # 336 as she thought the discharge was considered Against Medical Advice. Social Worker #1 and Billing Office	F 622	for discharge is in the medical record. The Administrator will be responsible for forwarding the results to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 622	Continued From page 15 Manager #1 confirmed that Resident #336 explained to them that she had experienced car trouble and that was why she was not able to come back on the evening of 2/11/24 as planned and that she tried to contact the facility to let them know but staff did not answer the phone. Resident #336 also indicated that she wanted to remain in the facility but due to the Regional Billing Office Manager's directive Social Worker #1 told Resident #336 she had to be discharged from the facility. An attempt was made to interview Resident #336 however she was no longer a resident at the facility and there was no contact information available. Multiple attempts were made to interview Resident #336's physician at the time of her discharge, but attempts were not successful. Multiple attempts were made to interview the Regional Billing Office Manager, but attempts were not successful. Multiple attempts were made to interview Resident #336's emergency contact, but attempts were not successful. An interview was conducted with Interim Administrator on 11/7/24 3:28 pm. He indicated that the internal staff received misdirection regarding Resident #336's discharge and that Resident #336 should not have been discharged as the facility was able to meet the resident's needs. He further indicated Resident #336 should have been permitted to stay at the facility.	F 622		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg	F 624		12/10/24

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F 624	Continued From page 16 CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and physician interview, the facility failed to provide a safe and orderly discharge for 1 of 3 residents (Resident # 336) reviewed for discharge. On 2/11/24 at 12:30 pm Resident #336 signed out of the facility on leave of absence with an expected return time of 9:30 pm. Due to transportation issues, Resident #336 was not able to return to the facility until 2/12/24 and was informed that she had been discharged and therefore could not remain in the facility. Resident #336 was not provided with discharge instructions or prescriptions, and the discharge location was not verified. This resulted in Resident #336 going to the hospital to get her medications refilled. Resident #336 remained in the hospital under observation until she was readmitted to the facility on 2/15/24. The findings included: Resident #336 was initially admitted to the facility on 12/2/23 with diagnoses which included chronic pain, opioid dependence, intentional self-harm by other firearm discharge and anxiety. Review of Resident #336's admission Minimum	F 624	Resident #336 no longer resides in the facility. Residents residing in the facility have the potential to be affected by the deficient practice. The Administrator audited the last 30 days of discharges to ensure that safe and orderly transfer/discharge took place. This included reviewing to ensure the resident was discharged with instructions and prescriptions. Education was provided to the Social Worker by the Regional Nurse Consultant regarding providing a safe and orderly to transferring/discharging residents. The education included providing and documenting sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Furthermore the Social Worker was instructed to provide instructions and prescriptions. Newly hired social worker(s) will be provided the education in orientation from the Administrator. The Administrator or designee will audit	

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F 624	Continued From page 17 Data Set (MDS) dated 12/8/23 revealed the resident was cognitively intact and was independent with activities of daily living. Review of a late entry progress note completed by Social Worker #1 on 2/13/24 revealed Resident #336 had been away from the facility for over 24 hours and Social Worker #1 had attempted to contact the emergency contact but was not able to leave a voicemail. A review of hospital records revealed Resident #336 was seen in the hospital emergency department on 2/13/24 at approximately 12:15 pm and was accompanied by a family member. The hospital record revealed that Resident #336 had requested her medications to be refilled, was asymptomatic and had no physical complaints. The facility was contacted for a list of her current medications on 2/13/24. Resident #336 was placed in psychiatric observation due to her history of psychiatric behaviors and the need to provide a safe environment. Review of Resident #336's admission Minimum date set (MDS) dated 2/18/24 indicated Resident #336 was readmitted to the facility on 2/15/24 from the hospital. A review of physician orders for February 2024 revealed no physician order for discharge on 2/12/24. An interview was conducted with Social Worker #1 and Billing Office Manager #1 on 11/6/24 at 2:12 pm. Social Worker #1 and Billing Office Manager #1 indicated that Resident #336 returned to the facility from her leave of absence on 2/12/24 at approximately 12:00 pm. They	F 624	two discharged residents a week for 12 weeks to ensure that a safe and orderly transfer/discharge was provided. The Administrator will be responsible for forwarding the results to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 624	Continued From page 18	F 624		

were instructed by the Regional Billing Office Manager to not allow Resident #336 to remain in the facility and to discharge her due to her being gone from the facility over 24 hours, which ended her insurance coverage. Social Worker #1 further revealed that she did not do any discharge planning for Resident # 336 as she thought the discharge was considered Against Medical Advice. Social Worker #1 and Billing Office Manager #1 confirmed that Resident #336 explained to them that she had experienced car trouble and that was why she was not able to come back on the evening of 2/11/24 as planned and that she tried to contact the facility to let them know but staff did not answer the phone. Resident #336 also indicated that she wanted to remain in the facility but due to the Regional Billing Office Manager's directive Social Worker #1 told Resident #336 she had to be discharged from the facility.

An attempt was made to interview Resident #336 however she was no longer a resident at the facility and there was no contact information available.

Multiple attempts were made to interview Resident #336's physician at the time of her discharge but attempts were not successful.

Multiple attempts were made to interview the Regional Billing Office Manager, but attempts were not successful.

Multiple attempts were made to interview Resident #336's emergency contact but attempts were not successful.

A telephone interview was conducted the Vice

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F 624	Continued From page 19 President of Business Development on 11/6/24 at 1:45 pm. She revealed she was contacted by the hospital staff during Resident #336's stay but did not recall the exact date. She further indicated that she was contacted by the hospital as they wanted to make her aware that Resident #336 had been discharged from the facility without a discharge location or medications. She further revealed that once she was made aware she contacted the facility to instruct them that the discharge was in error and the facility needed to readmit Resident #336 back to the facility and she was readmitted on 2/15/24. A telephone interview was conducted with the Medical Director on 11/7/24 at 12:20 pm. He indicated that upon review of Resident #336's MDS assessments, medications and hospital records he did not feel that the discharge contributed to medical distress. He further explained that she was independent with activities of daily living and the hospital record confirmed this by stating that she was asymptomatic at the time she entered the hospital emergency department. An interview was conducted with Interim Administrator on 11/7/24 3:28 pm. He indicated that the internal staff received misdirection regarding the discharge and that Resident #336 should have been allowed to remain in the facility.	F 624		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 636		12/10/24

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functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the

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F 636	Continued From page 21 timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview, the facility failed to comprehensively assess a resident in the area of weights for 1 of 3 residents (Resident #50) reviewed for nutrition. The findings included: Resident #50 was admitted to the facility on 9/18/23. Resident #50's physician order dated 2/26/24 stated monthly weight every Monday for monitoring. The quarterly Minimum Data Set (MDS) assessment dated 6/10/24 revealed Resident #50 was cognitively intact. The MDS indicated Resident #50's height was 71 inches, and his weight was left blank. Weight loss 5% or more was not assessed and weight gain was identified as not assessed.	F 636	Resident #50 monthly weight has been obtained and documented. Residents residing in the facility have the potential to be affected by the deficient practice. The MDS coordinator reviewed MDS assessments for the last two weeks to ensure the weight was assessed. Education was provided to the MDS coordinator, nurses and certified nurse aides by the Director of Nursing and Assistant Director of Nursing on the need to ensure resident weights are completed and documented as ordered. Furthermore, the MDS coordinator was educated to not leave these areas blank but to request a weight if it is identified as not assessed. Newly hired MDS nurses will receive the education from the Director of Nursing.	

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F 636	Continued From page 22 Review of Resident #50 quarterly MDS assessment dated 9/12/24 indicated he was cognitively intact. The MDS indicated Resident #50's height was 71 inches, and his weight was left blank. Weight loss 5% or more was not assessed and weight gain was identified as not assessed. Review of Resident #50's care plan created 10/14/23 and revised on 9/25/24 stated he had nutritional problems or potential nutritional problems related to high Body Mass index (BMI) status. The goal stated Resident #50 would have gradual weight loss (1-2 lbs. per month) through the review period. The goal further indicated Resident #50 would maintain adequate nutritional status as evidenced by maintaining weight, no signs or symptoms of malnutrition. The interventions included Registered Dietician to evaluate and make diet change recommendations as needed. Resident #50 electronic weight record was reviewed. The weight record revealed one recorded weight of 246.7 pounds (lbs.) on 10/8/24. There were no recorded weights for February 2024 through September 2024. Dietary note dated 9/25/23 stated Resident #50 was reviewed for admission to the facility. The dietary note further indicated Resident #50's appetite was 76-100% of meals consumed. His height was documented as 71 inches, and his weight was 224 lbs. Resident's body mass index (BMI) was 31.3 and continue to monitor weight monthly. There were no other dietary notes or assessments located in the electronic medical record.	F 636	The MDS coordinator or designee will audit two residents quarterly assessments a week for 12 weeks to ensure the weight has been assessed and documented on the quarterly assessment. The Director of Nursing or designee will forward the results of the audit to the QAPI Committee monthly for 3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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An observation and interview was conducted with the Corporate Nurse Consultant on 11/6/24 at 10:28 AM. She stated the reason Resident #50's weights were not consistently taken was due to the facility not having a system in place. She stated October 2024 weights had been documented. Resident #50's weight was taken by mechanical lift during the observation, and he weighed 227.7lbs.

Interview with the MDS Coordinator on 11/6/24 at 11:47 AM indicated the MDS assessment had a 30-day lookback period. She further indicated the facility had a MDS coordinator that worked remotely and had completed the assessment for Resident #50. If the MDS Coordinator did not have weights documented for 30 days prior to the assessment, it would have not been put on the assessment.

Interview with the Dietician on 11/6/24 at 4:04 PM revealed she had not completed a dietary assessment on Resident #50 since her dietary note dated 9/25/23. She had not documented a dietary assessment because Resident #50 had not flagged for weight loss. She only completed monthly dietary note for residents who had wounds, were tube fed, had weight loss or received dialysis.

During the interview the Dietician indicated she had observed the missing weights in the electronic medical record. She was unsure why Resident #50's weights were not obtained.

Interview with the Director of Nursing (DON) on 11/7/24 at 3:35 PM stated she had no idea staff were not taking Resident #50's weight monthly.

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(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 636	Continued From page 24 She stated she noticed the facility was having issues obtaining weights which was why October 2024 weights were obtained. She further indicated she was unsure why the MDS assessment did not include Resident #50's weight.	F 636		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Corporate Nurse Consultant and Physician interview the facility failed to follow physician orders to obtain a monthly weight (lbs.) for 1 of 3 residents (Resident #50) reviewed for nutrition. The findings included: Resident #50 was admitted to the facility on 9/18/23 with a diagnosis that included hypertension, depression and fractures. Resident #50's physician order dated 2/26/24 stated "monthly weight every Monday for monitoring". The quarterly Minimum Data Set (MDS) assessment dated 6/10/24 revealed Resident #50 was cognitively intact. Resident #50 had no upper body impairment and 1 lower extremity impairment. The MDS further indicated Resident #50's height was 71 inches, and his weight was	F 658	Resident #50 weight has been obtained and documented. Residents residing in the facility have the potential to be affected by the deficient practice. The Unit Manager and Assistant Director of Nursing reviewed the weights for current residents for the last 30 days to ensure they were documented in the medical records. Education was provided by the Director of Nursing and Assistant Director of Nursing to the nurses and certified nurse aides on the importance of following a physician□s order and completing monthly weights as ordered. The Director of Nursing or designee will audit 5 residents a week for twelve weeks to ensure monthly weights are documented as ordered.	12/10/24

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F 658	Continued From page 25 left blank. Weight loss 5% or more and weight gain was not assessed. Review of Resident #50 quarterly MDS assessment dated 9/12/24 indicated he was cognitively intact. Resident #50 had no upper body impairment and 1 lower extremity impairment. The MDS further indicated Resident #50's height was 71 inches, and his weight was left blank. Weight loss 5% or more was and weight gain was not assessed. Resident #50 electronic weight record was reviewed. There were no monthly weights for February 2024 through October 2024. The weight record revealed one weight of 246.7 lbs. dated 10/8/24. An observation of Resident #50's weight taken via mechanical lift and interview was conducted with the Corporate Nurse Consultant on 11/6/24 at 10:28 AM. She stated the reason Resident #50's weights were not consistently documented was because the facility did not have a system in place. Weights had been obtained for October 2024 when it was identified weights were not being obtained. The Corporate Nurse Consultant obtained Resident #50's weight by mechanical lift, and he weighed 227.7 lbs. Interview with the Director of Nursing (DON) on 11/7/24 at 3:35 PM stated she had no idea staff were not taking Resident #50's weight monthly as ordered. She stated she noticed the facility was having issues obtaining weights which was why October 2024 weights were obtained. She further indicated she was unsure why the MDS assessment did not include Resident #50's weight.	F 658	The Director of Nursing will forward the results of the audit to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 658	Continued From page 26 Interview with the Medical Director on 11/8/24 at 8:33 AM indicated weights should be documented monthly as ordered. He further indicated a physician order should continue until it was discontinued. The Interim Administrator was interviewed on 11/8/24 at 2:20 PM stated if weights were unable to be taken, he would expect the concern to be brought to the attention of the clinician and the physician. Staff should follow the physician order as written until discontinued.	F 658		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide	F 688	Resident #48 is currently on therapy caseload for splinting.	12/10/24

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F 688	Continued From page 27 restorative range of motion and the application of the splinting devices as recommended by the occupational therapist for 1 of 2 sampled resident (Resident #48) reviewed for limited range of motion. Findings included: Resident #48 was admitted to the facility on 3/24/23 with diagnoses which included: hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting the left non-dominant side and a left-hand contracture. The quarterly Minimum Data Set (MDS) assessment dated 9/20/24 indicated Resident #48 was cognitively intact and had range of motion impairments of one side of her upper and lower extremities. The care plan dated 9/16/24 revealed Resident #48 required assistance with her activities of daily living (ADL). Interventions included physical, occupational and speech therapies were to evaluate and treat as indicated/ordered. Review of the occupational therapy discharge summary dated 9/25/24 revealed Resident #48 was referred to therapy for restorative nursing program and had reached her maximum potential. AAROM (active assisted range of motion) and HEP (home exercise program) was provided to the resident to prevent further subluxation (partial dislocation) in her left shoulder. The Occupational Therapist (OT) recommended a restorative ROM (range of motion) program and restorative splint and brace	F 688	Residents residing in the facility have the potential to be affected by the deficient practice. The Director of Rehabilitation conducted an audit on the current residents to determine if they should be receiving restorative range of motion and the application of the splinting devices. Education was provided to the nurses and certified nursing assistants by the Director of Nursing and Assistant Director of Nursing in regards to ensuring that restorative is provided and splinting devices applied as ordered. The Unit Manager and Assistant Director of Nursing will audit five residents a week that require range of motion and/or splinting for a total of twelve weeks. The Administrator will forward the results of the audit to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 688	Continued From page 28	F 688		

program. Resident #48 was to wear a "T"- splint up to 6-7 hours a day to prevent further contracture. The prognosis to maintain CLOF (current level of functioning) was good with consistent staff follow-through.

During an observation and interview on 11/04/24 at 1:10 p.m., Resident #48 was in her room in her wheelchair feeding herself lunch using her right hand. The resident's left arm was bent towards her chest area and the right hand was fisted with her fingers towards her palm. The resident stated she received therapy for her contractures but had not received any follow-up with exercises, other than what she attempted, herself. A palm guard was observed hanging from a bed rail on the right side of the resident's bed. The resident revealed she also had splinting devices but was unable to apply the splints, herself.

On 11/07/24 at 1:30 p.m., Resident #48 was observed in her room in her wheelchair in conversation with nursing assistant (NA#2) while propelling herself using her right arm and hand to the bathroom. The resident was observed with a clear, plastic brace to her left lower leg but no splinting devices on her left arm which was bent close to her body and the left hand was curled in a fist.

During an interview on 11/07/24 at 1:45 p.m., NA#2 stated Resident #48 had left arm and left leg contractures and was able to apply her splinting devices, herself. NA#48 stated she has observed the resident wearing the hand palm guard but not the arm splint. When asked, the NA#2 showed this Surveyor the two splinting devices in the top drawer of the resident's chester drawer which she described as the resident's blue

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F 688	Continued From page 29 arm splint and a black leg splint. During an interview on 11/07/24 at 3:39 p.m., the Regional Nurse Consultant stated she was unable to locate a physician's order for Resident #48's splinting devices and exercise program. She stated once a resident was discharged from rehabilitation therapy, the therapist would educate the staff, and a physician's order should have been completed based on the recommendations from the therapist. The Regional Nurse Consultant further revealed that the monitoring process should have involved the nursing staff (nurses or nursing assistants) documenting the date and time the splinting devices were applied and removed from the resident. A telephone interview was conducted with the occupational therapist (OT) on 11/07/24 at 3:57 p.m. She stated she worked in the facility's rehabilitation department as a prn (when needed) OT. The OT recalled that at the time of Resident #48's discharged from occupational therapy, the plan was for the resident to discharge home with her family who would assist the resident in application of her splinting devices and assist with her exercise program. The OT concluded that if the resident remained in the facility, then it was nursing's responsibility to obtain a physician's order to apply the splints and provide the exercises.	F 688		
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		12/10/24

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F 689	Continued From page 30 §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 observation, record review, and interviews of staff, the facility failed to provide care in a safe manner when a resident rolled off a bed raised to waist height onto the floor. Resident #7 sustained a laceration to the left side of her head which required 5 staples. This deficient practice affected 1 of 4 residents reviewed for accidents. (Resident #7) Findings included: Resident #7 was admitted to the facility on 12/27/17 with diagnoses of Alzheimer's dementia and osteoarthritis. A review of Resident #7's record documented she had the diagnoses added on 9/23/21 of adult failure to thrive, severe protein-calorie malnutrition, cognitive communication deficit, repeated falls, and dysphagia. Resident #7's quarterly Minimum Data Set (MDS) dated 7/26/24 documented Resident #7 was unable to participate in a cognitive assessment. The resident had no behaviors or refusal of care and no falls. The MDS also indicted the resident was receiving hospice services, required extensive assistance with bed mobility, transfers, incontinence care, and bathing. Resident #7's care plan dated 8/9/24 documented she was at high risk for falls due to history of falls, cognitive impairment, and decreased mobility.	F 689	Resident #7 still resides in the facility. Resident #7 has had no further incident. Residents residing in the facility that require assistance in bed with activities of daily living have the potential to be affected. The Director of Nursing reviewed falls for the last 30 days to ensure that no fall was secondary to providing care in an unsafe manner. Education was provided to nurses, certified medication aides and certified nurse aides by the Director of Nursing and Assistant Director of Nursing regarding providing care safely to residents in bed. Director of Nursing will audit five falls a week to ensure that if there was care being provided during the time of the fall that care was being provided safely. The Administrator will forward the results of the audit to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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The interventions were to report any falls to the physician and to refer to physical therapy as needed. The resident required extensive assistance with all activities of daily living.

Resident #7's fall incident report dated 11/1/24 written by Nurse #1 documented during care with the Nursing Assistant (NA), the resident became combative. She fell out of bed and sustained a laceration to the left side of her head. The resident was confused and oriented to person.

Resident #7's Emergency Department record dated 11/1/24 documented she was seen after a fall at the facility and sustained a laceration to the left side of her head. The laceration was no longer bleeding. The resident had fragile skin, and five staples were used to close the laceration. The resident was confused and non-verbal. The resident returned to the facility after a check of her brain for bleeding and was not admitted.

The nurses' note dated 11/04/24 at 1:33 pm was a late entry written by Nurse #1 that documented Resident #7 left the facility at 1:45 pm with Emergency Medical Service (EMS) by stretcher on 11/1/24 due to a laceration to the left side of her head after rolling out of bed and hitting her head on the wall edge when the NA #1 was providing care.

On 11/4/24 at 9:40 am an observation was made of Resident #7. She had 5 large staples on her left forehead that had surrounding bruise. An interview was attempted but the Resident was confused and mumbled at times.

On 11/4/24 at 10:40 am an interview was

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conducted with NA #2. NA #2 stated she knew Resident #7 well and was nearby on 11/1/24 when NA #1 called for help after the resident's fall. NA #2 had not seen the fall but observed the resident on the left side of her bed, lying on her left side with a laceration to the left side of her head. NA #1 held pressure with a washcloth on the Resident's head and NA #2 went to find the nurse assigned (Nurse #1) to report. The resident was known to have behaviors during care when moving the resident but was unable to roll off the bed by herself. The NA reported that Resident #7 required one staff member for all care except transfer which required two staff members.

On 11/5/24 at 11:20 am an interview was conducted with Nurse #1. Nurse #1 stated she was aware Resident #7 had verbal and physical behaviors when moved during care and believed it was from her dementia. Nurse #1 stated she was assigned to Resident #7 on 11/1/24 when she fell out of bed. At 3:30 pm a follow-up interview was conducted with Nurse #1. Nurse #1 stated she was aware the resident could be combative with her arms and used foul language during personal and incontinence care, and it was believed this behavior was related to her dementia. Nurse #1 stated the resident could not roll herself in the bed or out of the bed. Nurse #1 stated that she was informed by NA #2 that the resident fell out of bed on 11/1/24 during care by NA #1 when the resident was resisting care when turned. Nurse #1 stated upon entry to the resident's room she observed the resident on the floor, left side of bed near the wall, on her left side and was bleeding on the left side of her head from a laceration. NA #1 was holding pressure on the laceration to the head. NA #1 had

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provided incontinence care to the resident and informed Nurse #1 that the resident was resisting care when rolled. The resident rolled during the behavior while on her left side and fell off the bed. Nurse #1 stated that the staff was responsible for preventing the resident from rolling off the bed during care and the accident could have been avoided by not letting go of the resident while on her side.

On 11/6/24 at 8:20 am an interview was conducted with NA #1. NA #1 stated she provided incontinent care to Resident #7 on 11/1/24 when the resident rolled out of bed. The resident frequently had not liked to be rolled during incontinence care. The resident was known to be calm when not "touched." The NA had to bend the resident's knee to roll her. The resident's behavior started when rolling her for care. On 11/1/24 during care, the resident was rolled to her left side and the resident started to hit the NA and yell. The NA moved her hand off the resident so she could calm. The resident rolled onto the floor. The bed was elevated to waist height for care. The resident hit the left side of her head on the wall corner and was bleeding. The nurse (Nurse #1) was informed by NA #2 about the incident while NA #1 remained with the resident. NA #1 stated she held pressure on the resident's head to stop a moderate amount of bleeding. EMS was contacted and the resident was transferred to the Emergency Department.

On 11/6/24 at 2:10 pm an interview was conducted with the Corporate Nurse. Resident #7's fall was discussed with the Consultant. She stated, "it could be possible the resident's pain in her legs with behavior during care contributed to her fall out of bed."

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F 689	Continued From page 34 On 11/6/24 at 2:40 pm an interview was conducted with the Administrator. The Administrator stated he was aware of Resident #7's fall and the fall was discussed during morning clinical meeting. He further stated he was just made aware (11/6/24) by the Corporate Nurse that the resident's pain could have contributed to her behavior with resulting fall.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and physician interviews, the facility failed to ensure a resident receiving dialysis services had a physician's order for dialysis services, a care plan and failed to monitor after dialysis treatments. This was for 1 of 1 resident reviewed for dialysis (Resident #64). The findings included: Record review of the hospital history and physical dated 5/27/24 as the orders for dialysis, revealed right sided permacath access (a flexible tube that's inserted into a blood vessel in the neck or upper chest to provide dialysis treatment), hemodialysis every Monday, Wednesday and Friday.	F 698	Resident #64 dialysis orders and care plan have been updated. Residents that reside in the facility that receive hemodialysis have the potential to be affected by the deficient practice. The Assistant Director of Nursing audited current residents receiving dialysis services to ensure that a physician order, care plan and post treatment monitoring orders were in place. Education was provided by the Director of Nursing and Assistant Director of Nursing to the nurses regarding the need to make sure that residents receiving dialysis had orders in place for dialysis and post treatment care as well as care plan. Newly	12/10/24

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F 698	Continued From page 35 Record review of the hospital discharge summary dated 6/21/24 revealed Resident #64 had permacath and to return to the dialysis schedule of Monday, Wednesday and Friday. Resident #64 was admitted to the facility on 6/21/24 with diagnoses including end-stage renal disease and dependence on renal dialysis. Resident #64's admission assessment dated 6/22/24 completed by the Unit Manager revealed no documentation of Resident #64's dialysis access or status. Review of the care plan for Resident #64 for barrier precautions dated 6/25/24 and revised on 8/20/24 specified enhanced barrier precautions related to dialysis. The goal was to be free of symptoms of infection. The intervention was to follow the enhanced barrier precaution guidelines when providing close contact resident care or wound care. The review revealed no further information regarding the resident's going to dialysis, care regarding the resident due to requiring dialysis, or care when the resident returned from dialysis. A review of Resident #64's quarterly Minimum Data Set (MDS) assessment dated 9/27/24 revealed he was cognitively intact, and he received dialysis while a resident. Resident # 64's medical record revealed no physician's order for dialysis services. Review of Resident 64's medication administration record and the treatment record for the months of June 2024, July 2024, August	F 698	hired nurses will receive education during orientation from the Assistant Director of Nursing. All dialysis orders for residents will be reviewed daily in the clinical IDT morning meeting ensuring documentation was completed for monitoring dialysis pre/post care. The Assistant Director of Nursing or designee will audit five residents a week for twelve weeks to ensure that dialysis orders and the care plan are in place. The Administrator will forward the results of the audit to the QAPI Committee monthly x3 months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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2024, September 2024, and October 2024 through November 5, 2024, revealed no documentation of the monitoring of the dialysis permacath, or record of vital signs when the resident returned from dialysis.

An interview on 11/05/24 at 12:05 PM, Resident #64 indicated he went to dialysis on Mondays, Wednesdays, and Fridays. He stated the staff did not check his permacath or take his blood pressure when he returned from his dialysis treatments. He indicated the nursing staff returned him to his bed and the nurse restarted the tube feeding. An observation revealed Resident #64 had a right subclavian (at the collarbone) permacath with dry dressing.

An interview on 11/05/24 at 2:34 PM, Nursing Assistant (NA) 5 indicated no vital signs were taken when Resident #64 returned from dialysis. When Resident #64 returned from dialysis he was returned to bed.
An interview on 11/06/24 at 10:11 AM with NA #7 indicated Resident #64 was ready for dialysis by 4:00 AM. She revealed when Resident #64 returned he was returned to bed and no vital signs were obtained.

An observation revealed on 11/06/24 at 10:18 AM, Resident #64 returned from dialysis services and was taken to his room. The staff assisted him to his bed and Nurse #4 connected Resident #64 to his tube feeding.

On11/06/24 at10:23 AM Nurse #4 was observed while she reconnected Resident #64's tube feeding. She returned to the nursing station and checked the communication book from hemodialysis. She indicated there was no

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message from dialysis besides his dry weight and vital signs. She stated she did not check the permacath dressing for bleeding. She indicated she was not aware of any required documentation or assessment after dialysis treatments.

During an interview on 11/6/24 at 11:15 AM, the MDS Nurse reviewed the current physician orders for November 2024 and stated there were no dialysis orders for Resident #64. When asked where the dialysis care plan was located for Resident #64, the MDS Nurse indicated it was under barrier precautions. She stated Resident #64 had nothing to monitor regarding dialysis, so the resident did not have a dialysis care plan.

In an interview on 11/7/24 at 10:22 AM, the Unit Manager indicated the facility provided transport to and from dialysis for dialysis residents on their scheduled dialysis days. Each dialysis resident had a communication book the nurses checked for orders when the resident returned. When asked about the process of admitting a resident from the hospital she indicated the admitting nurse was responsible for transcribing orders from the discharge summary from the hospital. The physician reviewed the orders and approved or changed them. The MDS nurse was responsible for the MDS assessment and the care plan. When asked if Resident #64 should have an order and a care plan for dialysis, she indicated he should and was unaware as to why he did not.

An interview on 11/7/24 at 1:06 PM, Director of Nursing indicated the facility had dialysis policies and procedures to follow for the care of residents who received dialysis. She revealed the

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F 698	Continued From page 38 admitting nurse was responsible for obtaining the dialysis order from the discharge summary. The MDS nurse was responsible for creating the care plan. Nurses should know to monitor the access site and vital signs and document in the progress notes and on the MAR. The Unit Manager was to review the orders for accuracy. Nursing staff were expected to know how to provide care for a dialysis resident. She reviewed the physician orders Resident #64 and indicated there was no new physician order for dialysis. A telephone interview was conducted on 11/7/24 at 1:56 PM with the Medical Director and he indicated the dialysis order was part of the hospital discharge summary. The order was part of the medical record. The nurses were to monitor a graft or fistula access for patency or a catheter for bleeding when a resident returned from dialysis treatment. The staff were to follow the facility protocol.	F 698		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, North Carolina (NC) Nurse Aide (NA) Registry Representative and staff interviews, the facility administration failed to have effective systems in place to identify when a nurse aide had an expired registry listing with the NC Nurse Aide Registry for 1 of 5 employees	F 835	Administrator #1 is no longer employed by the facility. Administrator #2 was educated by the Regional Nurse Consultant on the process for ensuring the certified nurse	12/10/24

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F 835	Continued From page 39 reviewed for sufficient nurse staffing (NA #4). The findings included: Nurse Aide (NA) #4 was hired by the facility on 5/23/2024. Review of NA #4's personnel file revealed NA #4's registry listing expired on 10/31/2024. Review of the NC Nurse Aide Registry online portal revealed NA #4's original test date was 11/12/2010 with a listing expiration date of 10/31/2024. A telephone interview was completed with NC Nurse Aide Registry representative on 11/07/2024 at 10:22 AM. The NC Nurse Aide Registry representative confirmed that NA #4's registry listing expired on 10/31/2024. Review of the nursing schedules from 11/01/2024 to 11/07/2024 revealed that NA #4 worked the following days: 11/01/2024, 11/02/2024 and 11/03/2024. NA #4 was assigned to the 300-hall from 7:00 AM to 7:00 PM. Review of NA #4's time sheet revealed she worked 3 days after her NA registry listing expired on 10/31/2024. On 11/01/2024, NA #4 worked the following hours: 7:23 AM to 7:23 PM. On 11/02/2024, NA #4 worked the following hours: 7:34 AM to 7:22 PM. On 11/03/2024, NA #4 worked the following hours: 7:25 AM to 7:26 PM. An attempt was made to contact NA #4 but was not successful. An interview with the Scheduler was conducted	F 835	assistants employed by the facility have a current registry listing. The Regional Nurse Consultant or designee will monitor the Administrator once weekly for three months to ensure the binder with certified nurse aides certifications is present and updated. The Regional Nurse Consultant or designee will bring these audits to the Quality Assurance Committee meeting monthly for 3 consecutive months. The Quality Assurance Committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance.	

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F 835	Continued From page 40 on 11/07/2024 at 9:28 AM. The Scheduler explained NA #4 was a current employee at the facility. The Scheduler continued to explain NA #4 was a nurse aide and her responsibilities included passing breakfast trays, providing resident care including bed baths, incontinence care, assisting with meals, and grooming. An interview with the Director of Nursing (DON) on 11/07/2024 at 9:50 AM stated the previous Staff Development Coordinator (SDC) would have verified NA #4's registry listing during pre-employment screening. The DON voiced the SDC position was currently not filled. The corporate office verified registry listings during pre-employment screening until the SDC position was filled. An interview with the Administrator was completed on 11/07/2024 at 10:09 AM who revealed there should be some type of tickler file or tracking system in place to monitor Nurse Aide registry listing expirations. He continued to explain around 30 days prior to the NA registry listing expiring, the DON should communicate with the employee about their license expiring so the employee can make necessary arrangements for their license renewal. The Administrator communicated there was no Staff Development Coordinator (SDC) in place currently, but this function will transition to that person when hired and trained. The Administrator verbalized NA #4 should not have been allowed to work with an expired registry listing.	F 835		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to	F 914		12/10/24

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F 914	Continued From page 41 assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews, the facility failed to provide a privacy curtain for 2 of 14 rooms on the 200-hall reviewed for privacy (Room #211 and Room #213). The findings included: 1.Resident #14 was admitted to the facility on 10/07/24 and resided in Room 211. The admission Minimum Data Set (MDS) assessment dated 10/14/24 revealed Resident #14 was cognitively intact for decision making. An observation and interview conducted with Resident #14 on 11/04/24 at 12:20 PM revealed Resident #14 did not have a privacy curtain that blocked him from the doorway. The resident shared a room with another resident. Resident #14 further revealed he had not had a privacy curtain since admission. Resident #14 stated he had expressed to nursing staff that he would like a curtain so he could not be seen from the hallway if someone was to open the door during care. An observation and interview with Nurse Aide (NA) #8 on 11/5/24 at 10:15 AM revealed Resident #14 had not had a privacy curtain since	F 914	Resident # 211 and #213 had privacy curtains hung on 11/6/24. Residents residing in the facility have the potential to be affected by the deficient practice. An audit was performed on resident rooms ensuring the placement of privacy curtains. This audit was conducted the week of 11/12/24 through 11/15/24. Any privacy curtain needed for a resident room identified was resolved with placement. Staff was educated on the placement/need of privacy curtains. This education was provided during the week of 11/12/24 through 11/15/24. Newly hired staff will be educated on the privacy of residents with the use of privacy curtains by the Assistant Director of Nursing or Director of Nursing. The Environmental Services Director will audit 10 resident rooms twice a week for twelve weeks to ensure the placement of privacy curtains. The Administrator will forward the results of the audits to the QAPI Committee	

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F 914	Continued From page 42 admission. NA #8 further revealed she had reported to the prior housekeeping director multiple times that curtains had been missing on the 200 Hall. NA #8 stated she was unaware why Resident #14's curtain had not been hung. An interview conducted with the house keeping aide on 11/7/24 at 9:45 AM revealed he had consistently worked on the 200 Hall and was not aware Resident #14's privacy curtain had not been hung. It was further revealed the prior housekeeping director would handle and hang privacy curtains. An interview was attempted with the previous housekeeping director on 11/07/14 at 10:15 AM and was unsuccessful. An interview and observation conducted with the Administrator and the Director of House Keeping on 11/05/24 at 10:45 AM revealed Resident #14 did not have a privacy curtain and expected all residents to have one. The Director of House Keeping indicated it was his first day in that role and the Administrator further revealed he was not aware the curtains had not been hung. 2. Resident #55 was admitted to the facility on 02/11/23 and resided in Room 213. The annual Minimum Data Set (MDS) assessment dated 09/19/24 revealed Resident #55 was cognitively impaired for decision making. An observation conducted with Resident #55 on 11/04/24 at 12:30 PM revealed Resident #55 did not have a privacy curtain and shared a room with another resident.	F 914	monthly for three months. The QAPI Committee will review the audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency monitoring.	

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An observation and interview with Nurse Aide (NA) #8 on 11/5/24 at 10:20 AM revealed Resident #55 had not had a privacy curtain in two to three months. NA #8 further revealed she had reported to the prior housekeeping director multiple times that curtains had been missing on the 200 Hall. NA #8 stated she was unaware why Resident #55's curtain had not been hung.

An interview conducted with the house keeping aide on 11/7/24 at 9:45 AM revealed he had consistently worked on the 200 Hall and was not aware Resident #55's privacy curtain had not been hung. It was further revealed he had normally checked curtains in residents' room but had missed that Resident #55 curtain was missing. It was further revealed the prior housekeeping director would handle and hang privacy curtains.
An interview was attempted with the previous housekeeping director on 11/07/14 at 10:15 AM and was unsuccessful.

An interview and observation conducted with the Administrator and the Director of House Keeping on 11/05/24 at 10:45 AM revealed Resident #55 did not have a privacy curtain and expected all residents to have one. The Director of House Keeping indicated it was his first day in that role and the Administrator further revealed he was not aware the curtains had not been hung.