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	345329	A. BUILDING ______ B. WING ______	C 12/17/2024

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GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

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E 000	Initial Comments A recertification and complaint survey was conducted from 12/09/24 through 12/12/24. The team returned to the facility on 12/17/24 to validate the credible allegation therefore, the exit was changed to 12/17/24. The facility was in compliance with the requirement CFR. 483.73, Emergency Prepardness. Event ID #0TJV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 12/09/24 through 12/12/24. The team returned to the facility on 12/17/24 to validate the credible allegation. Therefore, the exit was changed to 12/17/24. The following intakes were investigated NC00212561, NC00213899, NC00216474, NC00217704, NC00221086, NC00224337 and NC00224882. Two (2) of the ten (10) allegations resulted in deficiencies. Event ID #0TJV11. Past noncompliance was identified at: CFR 483.12 tag F602 scope and severity of J. The citation F602 constituted Substandard Quality of Care. Immediate jeopardy began on 02/05/24 and was removed on 06/06/24. An extended survey was conducted.	F 000		
F 602 SS=J	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 602		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/06/2025

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

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F 602	Continued From page 1 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, and detective interviews, the facility failed to protect the resident's (Resident #70) right to be free from misappropriation of property when Housekeeper #1 used Resident #70's debit card to set up a mobile payment application account on his [Housekeeper #1's] phone without Resident #70's permission or knowledge. Housekeeper #1 was alleged to have sent approximately $4,000.00 of unauthorized payments from Resident #70's bank account to his mobile payment application account from February 2024 to May 2024. Resident #70 stated, "I am poor" and "he took everything I had." He indicated he was very upset that someone he trusted had taken advantage of him and he was "worried to death" over the loss of money and the potential for identity theft. This deficient practice occurred for 1 of 3 residents (Resident #70) reviewed for abuse, neglect, and misappropriation of resident property. The findings included: Resident #70 was admitted to the facility on 1/05/24. A review of the quarterly Minimum Data Set (MDS) dated 10/05/24 indicated Resident #70 was cognitively intact. A review of the facility's reportable incidents revealed an initial allegation report dated 5/30/24	F 602	Past noncompliance: no plan of correction required.	

F 602 Continued From page 2 F 602

indicating the facility became aware on 5/29/24 that money was transferred from Resident #70's bank account to a former employee's (Housekeeper #1) mobile payment application account. The report indicated there was reasonable suspicion of a crime, and the alleged misappropriation of resident property was reported to law enforcement on 5/30/24.

A review of Resident #70's bank account records from January 2024 to May 2024 revealed there were transactions of sending money from Resident #70's bank account to mobile payment application accounts starting on 2/05/24 along with overdraft fees charged by the bank. There were five transactions on 2/05/24, each sending $10.00 to Housekeeper #1's mobile payment application account. Transactions sending money from Resident #70's bank account to various mobile payment application accounts, including Housekeeper #1's, continued to recur several times a day from 2/5/24 through 5/6/24 in amounts ranging from $5.00 to $60.00. The transactions made to mobile payment application accounts and the bank overdraft charges totaled approximately $4,000.00.

A review of the police department incident report indicated a report was filed on 5/10/24 at 11:11 AM concerning Resident #70 and stolen money from his bank account.

An interview with Resident #70 was conducted on 12/20/24 at 11:27 AM. Resident #70 stated he was very sick and had not been able to use his debit card or monitor his bank account after his admission to the facility. Resident #70 revealed he did not recall the date, but a week or 2 after he was admitted to the facility, he asked

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Housekeeper #1 if he would purchase him a drink from the facility's vending machine. He indicated he gave Housekeeper #1 his debit card, he purchased the drink and then returned his debit card. Resident #70 revealed that was the only time he recalled Housekeeper #1 having possession of his debit card. He revealed a few months later the Business Office Manager (BOM) came to see him to discuss paying his bill. Resident #70 indicated he realized his debit card was missing and he asked the BOM to assist him with calling the bank to request a new card. He stated when they called the bank, he was informed that his account had been overdrawn for several months due to debit transactions that were made to a mobile payment application account. Resident #70 revealed he never had an account with a mobile payment application, and the only time his debit card was used after his admission to the facility was when Housekeeper #1 purchased him a drink from the vending machine. He further revealed he was not aware of any other staff members having possession of his debit card which indicated to him Housekeeper #1 was responsible for taking his money. Resident #70 stated, "I am poor" and "he took everything I had." He indicated he was very upset that someone he trusted had taken advantage of him and he was "worried to death" over the loss of money and the potential for identity theft. Resident #70 indicated that he was interviewed by the police and wanted to press charges against Housekeeper #1, but there was not enough evidence to charge him, and the case was closed.

An interview with the BOM on 12/11/24 at 11:37 AM indicated she did not recall the date but at the end of April she met with Resident #70 to discuss

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F 602	Continued From page 4 payment of his monthly bill, and he told her he lost his debit card and needed assistance contacting the bank. She revealed they called the bank a few days later and were informed that Resident #70's account had been overdrawn since January and there were several transactions of sending money to a mobile payment application account. She indicated that Resident #70 did not know what a mobile payment application was and had never set up an account. The BOM stated she obtained Resident #70's bank account records with is his permission from January 2024 to May 2024 and reviewed them on 5/10/24. She revealed there were several transactions sending money to various mobile payment application accounts, one of which was Housekeeper #1's. The BOM stated she contacted the mobile payment application company, and they informed her Housekeeper #1 had opened an account linked to Resident #70's debit card. She stated she immediately notified the Former Administrator of the concern, and he called the police. The BOM indicated the police assigned a detective to the case and an investigation was completed but no charges were filed. She revealed when the detective requested records from the mobile application company, he was told they had no record of Housekeeper #1's account. She stated she worked with the bank and tried to get them to credit the money Resident #70 lost but they would only go back 60 days from the date they became aware of the fraudulent activity. She indicated that Resident #70 agreed to set up a trust account managed by the facility and his social security check began to directly deposit into the account in June. The BOM revealed that Resident #70 had an outstanding bill with the facility that she planned to write off.	F 602		

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An attempt was made to call Housekeeper #1 on 12/11/24 at 3:36 PM and the number was no longer in service.

A phone interview was conducted with the Former Administrator on 12/12/24 at 8:59 AM. He stated the BOM notified him on 5/10/24 that she reviewed Resident #70's bank account transaction records and identified concerns related to mobile payment application withdrawals made by Housekeeper #1. He revealed that Housekeeper #1 was no longer employed at the facility when the concern was identified. He indicated he filed a police report on 5/10/24. He indicated that the police assigned a detective to the case, and records were requested from the mobile payment application company, however they informed the police they had no records of Housekeeper #1's account. He stated the detective informed him on 5/30/24 that Resident #70's bank account records did not provide enough evidence to file charges against Housekeeper #1, and they would be closing the case.

A phone interview conducted with the Detective on 12/16/24 at 9:11 AM indicated the facility filed a police report on 5/10/24 related to Housekeeper #1 setting up a mobile payment application account linked to Resident #70's debit card without his knowledge or permission. He stated the facility provided Resident #70's bank account records which he reviewed and determined there was enough evidence to open a case. He indicated he obtained a search warrant requesting the mobile payment application company release the records of Housekeeper #1's account, however they informed him there

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was no record of the account. The Detective revealed that without records from Housekeeper #1's mobile payment application account there was not sufficient evidence to file charges and the case was closed.

The Administrator was notified of immediate jeopardy on 12/11/24 at 10:52 AM.

The facility provided the following corrective action plan:

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

On 05/10/2024, the Business Office Manager obtained bank statements for Resident #70 and identified on the bank statements that Housekeeper #1 transferred no more than $3,963.15 through a money transfer application from Resident #70's bank account to Housekeeper #1's phone application between 02/05/2024 - 04/08/2024. Housekeeper #1 no longer worked at the facility effective 03/07/2024. The facility recognized that residents who manage their own personal funds have the potential to be affected by the noncompliance of misappropriation of resident property.

On 05/13/2024, the Business Office Manager, with consent from Resident #70, requested a direct deposit for Resident #70's Social Security checks into his RFMS (Resident Fund Management System) account. Beginning on 06/03/2024 Resident #70's Social Security checks were direct deposited into his resident trust account managed by the facility. RFMS is a complete resident fund accounting system for

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F 602	Continued From page 7 handling resident funds, to provide banking solutions, such as direct deposit and direct debits. The Executive Director reported the misappropriation of Resident #70's property to local law enforcement on 05/10/2024. The Executive Director filed the initial allegation to the State agency on 05/30/24. On 05/24/2024, Resident #70 was seen by the psychiatric nurse practitioner, the progress note indicated Resident #70 denied feeling depressed, anxious, and stated Resident #70 left his room to socialize with others. He continued to be followed by psychiatric services. Resident #70's liability from June 2024 through December 2024 with a total balance of $628 has been written off without any penalty to the resident. The decision was made by the Regional Business Office Manager to write off the balance on 5/21/2024. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Business Office Manager audited the current Resident Financial Management System (RFMS) on 05/15/2024 to ensure no unauthorized activity had occurred. No discrepancies or suspicious activity were identified. Also, during this time no concerns were noted by any other residents/responsible parties regarding unauthorized activity with their personal banking accounts. No other residents/responsible parties reached out to the business office for additional assistance with their personal banking accounts. The Business Office Manager reconciled the asset account (bank account and register statement balance) to the resident trust fund	F 602		

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liability account (balance of residents account in the RFMS) to verify the accounts monthly. All disbursements made from the Resident Trust Fund must be documented with a properly signed withdrawal ticket. The facility maintains a pre-numbered withdrawal book with withdrawal tickets in a triplicate to record the disbursements made from the Resident Trust account. A Resident Trust fund statement is mailed to the patient and or Guardian/Responsible Party quarterly. The statement included all accounting transactions to include debits and credit. This process pertains to interviewable and non-interviewable residents with RFMS accounts. On 05/30/2024, the Social Worker interviewed alert and oriented residents to ensure no employee had asked any resident for money or use of their debit, credit, EBT (food stamps) and or Ucard (United Healthcare debit card). No issues or concerns identified. The RFMS reconciliation process was utilized for the non-interviewable residents. Staff were interviewed regarding misappropriation of resident property by the Executive Director and/or Director of Nursing on 05/30/2024. No concerns identified.

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

The Executive Director and/or Director of Nursing re-educated current staff including contracted staff with validation of understanding on the Abuse Policy with emphasis on misappropriation of resident property, unauthorized use of a resident's debit, credit, EBT and or UCard for personal use or gain on 05/30/2024 - 06/05/2024. Education also included the use of a sign out

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F 602	Continued From page 9 sheet for snacks and drinks purchases. The form included date, name, items purchased, amount given by the resident to the staff, amount returned to the resident, staff signature, resident signature, and a place to have two staff sign if the resident is unable to sign. The snacks and drinks form is located at the nursing station and is reviewed weekly by the Director of Nursing for accuracy to ensure the amount of money given by the resident to the staff minus the item purchased equals the amount of money returned to the resident. Newly hired staff will be educated in orientation. Staff were educated to not accept debit cards from residents for vending machine purchases on 06/05/2024. The Executive Director verbally educated Residents educated the use of debit cards by staff is not allowed for vending machine purchases on 06/05/2024 via room to room. Residents are made aware upon admission and throughout their stay of having the option to secure valuables. The Maintenance Director handled the request of a resident's need for a lock on their nightstand. A key is provided by the Maintenance Director and/or Executive Director. In the event the nightstand does not have locking capabilities, the Maintenance Director will install a lock and provide the key to unlock the nightstand to the resident and the spare key is in a locked box / drawer in the Maintenance Directors office. All residents/responsible parties were offered a RMFS account upon admission and can make changes any time during their stay with consent to the business department. Address how the facility will monitor its corrective actions to ensure the deficient practice will not recur:	F 602		

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F 602	Continued From page 10 On 06/05/2024, the Executive Director held an ADHOC Quality Assurance Performance Improvement meeting. The Executive Director presented the deficient practice of misappropriation of resident property and implemented a plan of action to include quality improvement monitoring and the frequency of monitoring. The Executive Director and/or Director of Nursing to complete quality monitoring of five residents weekly for twelve weeks to ensure residents are protected from misappropriation of personal property. Questions asked of the 5 residents included in the quality monitoring are "Do you have any concerns related to your finances to include your debit card, EBT card and/or U card?" and "Do you know who to report concerns to?". The Business Office Manager reconciled the asset account (bank account and register statement balance) to the resident trust fund liability account (balance of residents account in the RFMS) to verify the accounts monthly. All disbursements made from the Resident Trust Fund must be documented with a properly signed withdrawal ticket. The facility maintains a pre-numbered withdrawal book with withdrawal tickets in a triplicate to record the disbursements made from the Resident Trust account. A Resident Trust fund is mailed to patient and or Guardian/ Responsible Party quarterly. The statement includes all accounting transactions to include debits and credit. This process pertains to interviewable and non-interviewable residents. Members of the Quality Assurance Performance Improvement committee include Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, the Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records Clerk, Central	F 602		

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F 602	Continued From page 11 Supply Clerk, Admissions Director, Nurse Managers, Dietary Manager, and the Environmental Services Director. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting monthly to ensure ongoing compliance for 3 months. Quality Improvement monitoring schedule will be modified based on findings of monitoring. The Executive Director is responsible for overseeing the plan of correction. The center Executive Director alleges compliance 06/06/2024. Alleged date of IJ removal: 06/06/24. Validation of the facility's corrective action plan was conducted 12/17/24 through record review and staff interviews. A review of the resident trust account audits indicated they were completed by the Business Office Manager on 5/15/24 and no concerns or discrepancies were identified. An interview conducted with the BOM revealed she continues to audit and reconcile the resident trust accounts monthly and there have been no discrepancies identified. A review of the facility's monitoring audits conducted 6/6/24 through 8/20/24 revealed 5 alert and oriented residents were interviewed weekly and voiced no concerns related to their finances, misappropriation of their personal property or unauthorized charges on their personal bank accounts. Interviews were conducted with housekeeping, nursing, therapy and dietary staff which indicated they received education on the facility's abuse and reporting policy including misappropriation of resident property. The staff revealed the education also included the procedure to follow if a resident requests assistance with purchasing a snack or drink, which included only using cash (no	F 602		

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F 602	Continued From page 12 payment cards), documenting the amount of cash the resident gave them, the item purchased, and the amount of cash returned to the resident. The corrective action plan completion date and IJ removal date of 6/06/24 was validated.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		1/8/25

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F 609	Continued From page 13 by: Based on record review, and staff and Adult Protective Services (APS) Intake Social Worker interviews, the facility failed to file a report with the state agency no later than 24 hours after becoming aware of an allegation of misappropriation of resident property and failed to report the incident to APS for 1 of 3 residents reviewed for abuse (Resident #70). The findings included: A review of the facility's abuse, neglect, exploitation and misappropriation policy and procedure revised 11/16/22 read in part: Reporting/Response: Once an allegation of abuse is reported, the Administrator, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. The Abuse Coordinator will refer any or all incidents and reports of resident abuse to the appropriate state agencies. Resident #70 was admitted to the facility 1/05/24. A review of the police department incident report indicated on 5/10/24 at 11:11 AM they received a report that Resident #70 had money stolen from his bank account. A review of the facility's initial allegation report dated 5/30/24 revealed the facility became aware on 5/29/24 that Resident #70's bank statement had several transactions transferring money from his account to a former employee's (Housekeeper #1) mobile payment application	F 609	1. Residents # 70, was identified as having been involved in allegations of misappropriation of resident funds on 05/10/2024, with the initial report being filed with Department of Health and Human Services on 05/31/2024. At this time Adult Protective Services, was not notified of the incident. Adult Protective Services was notified of incident on 12/16/2024. 2. An Audit was conducted by Executive Director on reportable events for the past 90 days on 12/31/2024, verifying that all reportable events were reported within the reporting guidelines and that all parties (Law Enforcement and Adult Protective Services) were notified. No further discrepancies were noted. 3. On 01/03/2025 the Regional Vice President of Clinical Services provided education to the Executive Director and the Director of Clinical Services related to the reporting guidelines pertaining to misappropriation of resident funds. 4. The Executive Director or designee will conduct Quality Assurance/Performance Improvement monitoring on F609 to ensure that appropriate agencies are notified of all allegations of alleged violations 1x weekly for 12 weeks. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager,	

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F 609	Continued From page 14 account. The report indicated there was reasonable suspicion of a crime, and the alleged misappropriation of resident property was reported to law enforcement on 5/30/24 however it was not reported to Adult Protective Services. The report was completed by the Former Administrator. An interview with the Business Office Manager (BOM) on 12/11/24 at 11:37 AM indicated she did not recall the date but at the end of April she met with Resident #70 to discuss payment of his monthly bill, and he told her he lost his debit card and needed assistance contacting the bank. She revealed they called the bank a few days later and were informed that Resident #70's account had been overdrawn since January and there were several transactions sending money to a mobile payment application account. She stated she reviewed Resident #70's bank statements on 5/10/24 and there were several transactions sending money to various mobile payment application accounts, one of which was Housekeeper #1's. She indicated she contacted the mobile payment application company, and they informed her Housekeeper #1 had opened an account linked to Resident #70's debit card. The BOM revealed she immediately notified the Former Administrator of the concern, and a police report was filed on 5/10/24. A phone interview was conducted with the APS Intake Social Worker on 12/16/24 at 9:27 AM. She stated they had no record of the facility reporting an incident of misappropriation of property for Resident #70. A phone interview with the Former Administrator on 12/12/24 at 8:59 AM revealed the BOM was	F 609	Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring. 5. 01/08/2025	

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F 609	Continued From page 15 reviewing Resident #70's bank statements and there were several transactions transferring money from his account to Housekeeper #1's mobile payment application account. He stated the BOM notified him of the concern on 5/10/24 and he filed a police report. He further stated he did not submit an initial allegation report within 2 hours because he wanted to investigate it further along with the police to "see if it was anything." He revealed Housekeeper #1 was no longer employed at the facility when the concern was identified. He stated he submitted the initial allegation report on 5/30/24 once the police investigation was completed and they determined no charges would be filed against Housekeeper #1. The Former Administrator indicated because the police did not file charges against Housekeeper #1, he unsubstantiated the allegation of misappropriation and did not file a report with APS.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 2 residents reviewed for bladder continence (Resident #74 and Resident #35). Findings included: 1. Resident #74 was admitted to the facility on 10/19/2024 with diagnoses including a stage 4	F 641	1. Residents # 74 and # 35 were identified on the MDS as having a foley catheter and always incontinent. MDS was immediately corrected. 2. An Audit was conducted by the MDS Coordinator on 12/30/2024, verifying that continent of bladder status was correctly coded when the resident has a foley catheter on assessments completed in	1/8/25

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F 641

Continued From page 16

pressure ulcer to the sacrum.

A review of Resident #74's physician orders showed an order dated 10/21/2024 for a 16 French (FR) foley catheter with a 10 milliliter (ml) balloon due to stage 4 sacral pressure ulcer.

A review of Resident #74's admission Minimum Data Set (MDS) assessment dated 10/26/2024 revealed the resident was marked as having an indwelling catheter in place but was always incontinent of bladder.

An interview was completed on 12/12/2024 at 9:00 AM with the MDS Coordinator. During the interview the MDS Coordinator reported if a resident's MDS assessment was marked for an indwelling catheter then the continence needed to be marked as Not Rated. The MDS Coordinator explained Resident #74's MDS assessment should have been marked as Not Rated, instead of Always Incontinent for incontinence because he had an indwelling catheter. The MDS Coordinator also said the answers in the MDS assessments were system generated, and normally she would doble check those answers but somehow missed it.

During an interview on 12/12/2024 at 12:59 PM with the Director of Nursing (DON) she said she expected to see accurate coding on all MDS assessments.

An interview was completed on 12/12/2024 at 2:40 PM with the Administrator where she said she expected to see all MDS assessments completed accurately.

2. Resident #35 was admitted to the facility on

F 641

the last 30 days. No further discrepancies were noted.

3. On 01/03/2025 the Regional Vice President of Clinical Services provided education to the MDS Coordinator on coding continent of bladder status when the resident has foley catheter.

4. The Director of Nursing or designee will conduct Quality Improvement / Performance Improvement monitoring on F641 to ensure that MDS Assessments are correctly coding continent of bladder status when the resident has a foley catheter 3x/week for 8 weeks, then weekly for 4 weeks, then monthly for 6 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.

5. 01/08/2025

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F 641	Continued From page 17	F 641		

09/13/19 with diagnoses that included paraplegia, and neuromuscular dysfunction of bladder.

A review of Resident #35's most recent quarterly Minimum Data Set (MDS) assessment dated 11/06/24 revealed her to be cognitively intact and having an indwelling catheter and she was always continent of bladder.

A review of Resident #35's treatment administration record indicated she received indwelling catheter care every shift during the lookback period for the assessment.

During an interview with Resident #35 on 12/11/24 at 4:46 PM, she reported she had the catheter since before her admission to the facility. Resident #35 stated she had not had the catheter removed, even temporarily, since it was placed.

An interview with MDS Nurse #1 on 12/12/24 at 9:00 AM, she stated she had worked as the facility's MDS nurse since April of 2024. She reported Resident #35 had a catheter the entire time she had worked at the facility and that if a resident had a catheter for the entirety of the lookback period of a MDS assessment, then their bladder continence should be coded as "not rated". She went on to say the answers in the assessment system were typically automatically generated and she attempted to double check the answers. MDS Nurse #1 stated she thought she had changed Resident #35's continence to "not rated" but must have missed it.

An interview with the Director of Nursing on 12/12/24 at 2:04 PM revealed to her knowledge, Resident #35 had never had her catheter removed and that her bladder continence should

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F 641	Continued From page 18 have been coded as "not rated". She also indicated she expected MDS assessments to accurately reflect the resident, their care needs, and their conditions.	F 641		
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		1/8/25

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F 656	Continued From page 19 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop a comprehensive, individualized, and person-centered care plan in the area of behavior for 1 of 2 residents reviewed for behaviors (Resident #37). The findings included: Resident #37 was admitted to the facility on 6/28/2024 with the following diagnoses: cerebral infarction, anxiety disorders, metabolic encephalopathy, and vascular dementia. A review of the quarterly Minimum Data Set (MDS) assessment dated 10/22/2024 revealed Resident #37 had moderate cognitive impairment. The MDS further indicated no negative behaviors during the lookback period. On 12/9/2024 at 11:10 am an interview and observation were made of Nursing Assistant (NA) #4 sitting outside of Resident #37's room. The resident was observed lying in bed with his eyes	F 656	1. Residents # 37 were identified as care plans are not updated to reflect the need for 1:1 supervision. Care plan was immediately updated to reflect the needs of the resident. 2. An Audit was conducted by the MDS Coordinator on 12/31/2024, verifying that care plans accurately reflect the needs of the residents. No further discrepancies were noted. 3. On 01/03/2025 the Regional Vice President of Clinical Services provided education to the MDS Coordinator on updating care plans to accurately reflect the needs of the resident. 4. The Director of Nursing or designee will conduct Quality Assurance / Performance Improvement monitoring on F656 to ensure that care plans accurately reflect the needs of the resident 3x/week for 8 weeks, then weekly for 4 weeks,	

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F 656	Continued From page 20 closed. NA #4 reported she sat outside of the room since Resident #37 needed 1 on 1 supervision due to a history of physical behaviors with other residents and staff. An additional observation and interview were completed on 12/11/2024 at 10:26 am of Resident #37's room. NA #4 sat outside of the resident's room. NA #4 explained for the past 9 weeks or so she had sat outside of Resident #37's room to provide 1 on 1 supervision due to his behaviors. NA #4 also said there were staff members who sat with the resident on every shift. A review of Resident #37's care plan last reviewed on 12/6/2024 revealed no care plan in place for behaviors towards staff or residents. An interview was completed on 12/12/2024 at 9:00 am with the MDS Coordinator regarding Resident #37's care plan. During the interview the MDS Coordinator reported there should have been a care plan in place for Resident #37 related to his history of physical behaviors towards residents, especially since he had 1 on 1 supervision. The MDS Coordinator went on to say any type of changes in a resident, including 1 on 1 care would have been discussed in morning meeting and care planned, but she was unsure how this had been missed. On 12/12/2024 at 12:559 pm an interview was conducted with the Director of Nursing (DON) where she said she expected to see care plans be accurate to reflect the resident and their needs. The DON reported she was aware the resident had physical and verbal behaviors towards others and had been receiving 1 on 1	F 656	then monthly for 6 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring. 5. 01/08/2025	

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F 656	Continued From page 21 supervision since July of 2024 and should have been care planned. An interview was completed on 12/12/2024 at 2:40 pm with the Administrator. During the interview the Administrator said she expected to see all care plans completed accurately.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		1/8/25

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F 657	Continued From page 22 by: Based on record review and staff interviews, the facility failed to update a resident's care plan after she ingested wound cleanser for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #8). The findings included: Resident #8 was admitted to the facility on 06/27/14 with diagnoses that included Alzheimer's disease, anxiety, major depressive disorder, and adult failure to thrive. A review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated 03/08/24 revealed her to be severely impaired with no delusions, behaviors, or rejection of care. Resident #8 was coded as having wandering behaviors daily. Resident #8 required supervision with mobility and was coded as using a manual wheelchair. A review of facility incident and accident logs revealed a report dated 03/11/24 that indicated Resident #8 had obtained a bottle of wound cleanser and ingested an unknown amount. Per the incident report, Resident #8 was assessed along with telephone calls made to her representative, the on-call physician, and poison control. The report stated that Resident #8 was placed on observation and with no negative side effects observed. The report also indicated that Resident #8's confused cognition and wandering behaviors contributed to the incident. A review of Resident #8's care plan that was last reviewed on 08/01/24 revealed a care plan for Resident #8 being at risk for wandering behaviors due to dementia. Interventions included to assess	F 657	1. Residents # 8 was identified as care plan are not updated to reflect that she ingested a non-food item. Care plan was immediately updated to reflect the needs of the resident. 2. An Audit was conducted by the MDS Coordinator on 12/31/2024, verifying that care plans accurately reflect the needs of the residents. No further discrepancies were noted. 3. On 01/03/2025 the Regional Vice President of Clinical Services provided education to the MDS Coordinator on updating care plans to accurately reflect the needs of the resident. 4. The Director of Nursing or designee will conduct Quality Improvement/Performance Improvement monitoring on F657 to ensure that care plans accurately reflect the needs of the resident 3x/week for 8 weeks, then weekly for 4 weeks, then monthly for 6 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the	

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F 657	Continued From page 23 for elopement risk, distract Resident #8 from wandering by offering pleasant distractions, and to attempt to identify pattern of wandering and intervene as appropriate. There was no mention of the potential for Resident #8 to attempt to ingest non-food items or any interventions to prevent this from occurring. An interview with MDS Nurse #1 on 12/12/24 at 9:27 AM revealed the MDS nurse was typically responsible for updating care plans that were nursing specific with the Director of Nursing updating care plans when she was not working. MDS Nurse #1 stated she updated care plans anytime there is a change in condition with a resident, which would include changes in behavior. MDS Nurse #1 also stated she had no knowledge of Resident #8 ingesting wound cleanser and reported a behavior like that would be something that should be mentioned in her care plan. She reported she was not working at the facility at the time the incident occurred and provided the contact information for MDS Nurse #2, whom she indicated was the MDS nurse at the time of the incident. MDS Nurse #1 reported she did not know why Resident #8's care plan had not been updated. An interview with MDS Nurse #2 via telephone on 12/12/24 at 11:36 AM revealed she was the MDS Nurse in March of 2024 and reported she was unaware of the incident regarding Resident #8 ingesting wound cleanser. She also reported she did not recall if the interdisciplinary team discussed the incident after it occurred. MDS Nurse #2 reported if she had been made aware of the incident, she would have updated Resident #8's care plan to reflect the potential for Resident #8 to ingest non-food items. MDS Nurse #2	F 657	monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring. 5. 01/08/2025	

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F 657	Continued From page 24 reported she did not know why Resident #8's care plan had not been updated. An interview with the Director of Nursing on 12/12/24 at 1:52 PM revealed she was familiar with Resident #8 and that she was severely cognitively impaired and had wandering behaviors. She stated in March, she was made aware of an incident by Nurse #4 regarding Resident #8 ingesting an unknown amount of wound cleanser. She reported the day after the incident, it was discussed in the interdisciplinary team meeting, and she verified that MDS Nurse #2 was present. The Director of Nursing reported Resident #8's care plan should have been updated immediately after the interdisciplinary team meeting to reflect the potential for Resident #8 to ingest non-food items. She did not know why Resident #8's care plan had not been updated after she ingested the wound cleanser.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, Nurse Practitioner (NP) and Medical Director (MD) interviews, the facility failed to ensure the correct medications were administered to the correct resident for 1 of 5 residents reviewed for unnecessary medications (Resident #80). The findings included:	F 658	1. Residents # 80 sustained a medication error 12/08/2024. At this time the nurse notified on call provider and resident. 2. An Audit was conducted by Director of Nursing Services on 12/30/2024 looking at medication errors. No further	1/8/25

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Continued From page 25

Resident #80 was readmitted to the facility on 12/4/2024 with diagnoses that included peripheral vascular disease, neuropathy, and necrotizing fasciitis.

Review of the quarterly Minimum Data Set (MDS) assessment dated 10/12/2024 revealed Resident #80 was cognitively intact and was marked as receiving routine and as needed pain medication.

Review of a progress note written by Nurse #2 dated 12/8/2024 at 6:05 pm indicated Resident #80 was administered Baclofen (muscle relaxer) 10 milligram (mg) and Norco (pain reliever) 5/325 mg. Further review of the progress note revealed the on-call provider was notified and Nurse #2 was instructed to monitor the resident's level of consciousness, breathing, and cognition.

A review of an additional progress note written by Nurse #2 dated12/8/2024 at 6:43 pm revealed Resident #80 had been notified by Nurse #2 of receiving the wrong medication and he responded, "I did not even notice a difference."

A telephone interview was completed on 12/10/2024 at 2:05 PM with Nurse #2. During the interview Nurse #2 explained during her medication pass on 12/8/2024 she was putting medications into a medication cup for who she thought was Resident #80. Nurse #2 went on to say there was another resident sitting in his wheelchair behind her yelling while she was putting the medication in the medication cup, and she was distracted by it. Nurse # 2 said she administered the medications to Resident #80 and shortly afterwards she realized she had given Resident #80 the wrong medications. She stated

F 658

discrepancies were noted.

3. On 12/12/2024, the Director of Nursing provided education to the LPN who administered the incorrect medications related to medication administration. On 01/07/2025 the Director of Nursing provided education to the nursing department related to medication administration.

4. The Director of Nursing or designee will conduct Quality Improvement / Performance Improvement monitoring on F658 to ensure that ensure that medication administration is occurring without medication errors 2x/week for 12 weeks then monthly for 6 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring.

5. 01/08/2025

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F 658		F 658		

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the medications she had given to Resident #80 were Norco 5/325 mg and Baclofen 10 mg and were prescribed for Resident #59. Nurse #2 reported she informed Resident #80 that he received the wrong medications and took his vital signs before calling the on-call provider because she knew she would need to know the resident's vital signs before calling. Nurse #2 said she was told by the on-call provider to monitor Resident #80 for any change in level of consciousness (LOC) and breathing and call back if anything changed. Nurse #2 stated the Director of Nursing (DON) was also notified.

Review of Resident #80's current physician orders dated December 2024 revealed Resident #80 was ordered the following medications; Acetaminophen 325 mg (milligrams), give 1 tablet my mouth every 4 hours PRN (as needed) for pain, Roxicodone 5 mg, give 1 tablet my mouth every 4 hours PRN for severe pain with 7-10 pain rating, Gabapentin 600 mg, 1 tablet 3 times a day for neuropathy, and Methocarbamol (a muscle relaxer) 1000 mg, give 1 tablet three times a day for pain.

A review of the electronic medication administration record (MAR) for 12/8/2024 showed Resident #80 received Roxicodone 5 mg at 6:32 am and Gabapentin 600 mg was administered three times.

A review of Resident #59's MAR for 12/8/2024 revealed he received the medications that were ordered for him which included Baclofen 10 mg and Norco 5/325 mg for pain. Resident #59 reported pain rated at a 2/10.

Review of Resident #80's respirations revealed

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on 12/8/2024 at 6:30 PM his breathes per minute (BPM) were 18 and again on 12/8/2024 at 10:00 PM his BPM were 16.

An interview was completed on 12/10/2024 at 1:39 pm with Resident #80. During the interview the resident reported he received medication over the past weekend that was not his. Resident #80 went on to say the medication he received was weak pain medication and it did not really affect him because he was prescribed a stronger pain medication than what he received. Resident #80 reported he did not have any breakthrough pain due to receiving the wrong pain medication.

An interview was completed on12/11/24 at 11:36 AM with the DON revealed she was aware of a medication error that occurred on 12/8/2024. The DON explained she was notified by Nurse #2 that she had given Resident #80 a 10 mg Baclofen and a 5/325 mg Norco that was ordered for Resident #59. The DON said Nurse #2 went through all of the necessary steps following the medication administration including making sure Resident #80 was ok by checking his vital signs prior to calling the on-call provider and notifying the on-call provider and herself. The DON reported Resident #59 received his ordered medication. The DON explained neither resident had any complaints about pain and additional education will be provided to Nurse #2 to include Medication Administration involving the 6 rights and how to attempt to limit distractions.

On12/10/24 at 4:16 PM a telephone interview was conducted with the Nurse Practitioner (NP). The NP reported she had was notified of a medication error that occurred on 12/8/2024 by Nurse #2 about Resident #80 receiving pain medication

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F 658	Continued From page 28 and a muscle relaxer that was ordered for Resident #59. The NP stated she instructed Nurse #2 to monitor Resident #80's LOC and breathing and to reach back out if there were any changes. The NP explained she did not see the medication that Resident #80 received as a significant medication error due to the resident having no adverse outcomes and the medications and dosages he received were less than what he was prescribed. An additional interview was conducted on 12/12/2024 at 12:55 PM with the DON where she stated she expected all Nurses to follow the 6 rights of medication administration. The DON also said if a medication error occurred, she expected for the Nurse to notify herself, the provider, and the resident or responsible party. On 12/11/2024 at 2:36 PM an interview was completed with the Medical Director (MD). During the interview the MD reported the difference in medication and dosage that Resident #80 received would not be considered a significant medication error due to Resident #80 did not have any adverse effects related to the medications he received.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		1/8/25

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F 689	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, Resident, Wound Nurse and Medical Director interviews, the facility failed to provide care in a safe manner when a dependent resident (Resident #57) fell off the bed during incontinence care. The facility also failed to provide an environment free from a potential hazard when wound cleanser was left unattended on top of the treatment cart and an unmeasurable amount was ingested by Resident #8. This was for 2 of 4 residents reviewed for accidents. The findings included: 1. Resident #57 was admitted to the facility on 10/28/24 with diagnoses that included Fredrick's Ataxia (a condition that mainly affects the neuromuscular system and the heart and causes poor muscle control and coordination). A review of Resident #57's admission nursing assessment dated 10/28/24 indicated she was alert and oriented to person, place, time and situation. A review of a baseline care plan dated 10/28/24 indicated Resident #57 required extensive assistance of one staff for bed mobility, toileting and personal hygiene. A review of Resident #57's medical record revealed an order dated 10/28/24 to x-ray the right ankle. A review of an Incident Report dated 10/28/24 at 3:14 PM completed by Nurse #2 indicated Nurse #2 was notified that Resident #57 was on the	F 689	1. Residents # 57 sustained a fall on 10/28/2024 and Resident # 8 ingested non-food item; no harm or injury to either resident occurred. 2. An Audit was conducted by DON/designee on 12/30/2024, verifying that residents have a transfer assessment completed within 24 hours of admission for the past 30 days and that treatment and medication carts are free of non-food items within reach of residents. No further discrepancies were noted. 3. On 01/07/2025, the Director of Nursing provided education to the nursing department related to need for timely assessments following admissions and keep non-food items off the top of treatment carts and medications carts within reach of residents. 4. The Director of Nursing or designee will conduct Quality Improvement / Performance Improvement monitoring on F689 to ensure that admission assessments are completed within 24 hours and medication and treatments carts are free from items on the top within residents reach 3x/week for 12 weeks then monthly for 6 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director,	

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F 689 Continued From page 30

floor by Nurse Aide (NA) #3. Upon entering the room NA #2 informed Nurse #2 that she was providing incontinent care to Resident #57 and the Resident rolled out of bed. Resident #57 stated she rolled out of bed but denied hitting her head. The Resident indicated her right ankle was hurting. The report also indicated Resident #57 was alert and oriented to person, place, time and situation.

A review of Resident #57's medical revealed the result of the right ankle x-ray dated 10/29/24 was negative for fracture.

A review of an Investigative Report: Root Cause Analysis dated 10/29/24 completed by the Director of Nursing revealed Resident #57 was admitted 10/28/24 at 11:30 AM and fall occurred on 10/28/24 at 3:14 PM. NA #2 was providing incontinent care to Resident #57 and when the NA rolled the Resident onto her side while keeping her left hand on the Resident attempting to remove the soiled brief, Resident #57 rolled off the bed. Therapy to screen for bed mobility.

An interview and observation of Resident #57 were conducted on 12/09/24 at 11:29 AM. The Resident was lying in the middle of her bed watching television with her bed up against the wall and without side rails. Resident #57 stated, "they let me roll out of bed the first night I got here." Resident #57 explained that the first day she was admitted she was soiled and had to be changed. When Nurse Aide (NA) #2 came to provide care, the NA asked her how many people it took to take care of her and Resident #57 told NA #2 that it only took one person to provide care for her. The Resident continued to explain that when the NA turned her over, she continued to

F 689

Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring.

5. 01/08/2025

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F 689	Continued From page 31 roll over and out of the bed onto the floor. Resident #57 reported she hurt her right ankle, and they obtained an x-ray which showed no fracture. She stated her ankle hurt for a few days and since she was on routine pain medication the pain did not last very long at all. During an interview with NA #2 on 12/10/24 at 3:02 PM the NA confirmed that she was scheduled to work on Resident #57's hall on 10/28/24 and was present when the Resident rolled out of the bed. The NA explained that when she made rounds on Resident #57 on 10/28/24 at the end of her shift the Resident needed to be changed. The Nurse Aide reported that she received a brief report about Resident #57 from the Resident's family member who was with her during her admission and the family reported the Resident was total care. The NA stated she had never worked with Resident #57, so she was going to obtain assistance from another staff member when Resident #57 told her that it only took one person to change her. The NA explained that the Resident had soiled herself, so she gathered her supplies and raised her bed to about waist high and made sure the Resident was in the middle of the bed. She reported she then rolled Resident #57 over onto her left side and crossed her right leg over her left leg and while keeping her hand on the Resident's hip, she pulled the brief out from under the Resident and the Resident continued to roll over off the bed and onto the floor. NA #2 indicated she immediately went around to the other side of the bed and Resident #57 was lying on her left side. The NA asked the Resident if she was hurt, and Resident #57 stated she was not hurt but that she just wanted to get up out of the floor. The NA stated she went to the door and saw Nurse Aide	F 689		

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F 689	Continued From page 32 #3 standing in the hallway, so she asked her to come to the room because Resident #57 was on the floor. NA #2 stated NA #3 came into the room and saw that Resident #57 was on the floor and then went and got Nurse #2. NA #2 continued to explain that when Nurse #2 came into the room, she assessed Resident #57 before they transferred her back into the bed where she and NA #3 continued to provide incontinence care for the Resident. NA #2 reported she knew she could review the Resident's care plan to determine how many staff it took to provide care for Resident #57, but the Resident told her it only took one person to provide care for her but in retrospect she should have reviewed the care plan. An interview was conducted with Nurse Aide #3 on 12/10/24 at 4:14 AM. The NA explained that she was standing in the hallway near Resident #57's door when NA #2 hollered for her to come in the room because the Resident had fallen on the floor. The NA stated that when she went into the room and noticed the Resident lying on the floor, she asked her if she was hurt which the Resident denied and stated she just wanted to get out of the floor. NA #3 continued to explain that she went to get Nurse #2 who immediately went to the room and assessed Resident #57 who again reported to the Nurse that she was not hurt. She stated they transferred the Resident back to bed. NA #3 reported she understood that Resident #57 rolled out of bed when NA #2 rolled her over to provide incontinent care. She explained that she often worked with the Resident and one person can provide care for Resident #57 because she can help hold herself over. On 12/10/24 at 2:32 PM an interview was conducted with Nurse #2 who explained that she	F 689		

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was summoned to Resident #57's room on the afternoon of 10/28/24 and observed the Resident lying on the floor lying on her left side. The Nurse reported she assessed Resident #57, and she had no injuries, but she did complain of pain in her right ankle. The Nurse stated she along with other staff transferred the Resident back to bed where Nurse Aide #2 completed incontinence care. Nurse #2 continued to explain that both Nurse Aide #2 and Resident #57 informed her that the Resident told NA #2 that she could manage the Resident by herself before the NA began to provide the incontinent care. Nurse #2 stated that she reported the fall to the Director of Nursing who obtained an order for an x-ray of her right ankle.

An interview was conducted with the Director of Nursing (DON) on 12/11/24 at 10:13 AM. The DON explained that on the afternoon of 10/28/24 Nurse #2 informed her that Resident #57 had rolled off the bed during incontinence care provided by NA #2. Nurse #2 stated she had assessed Resident #57, and her only complaint was right ankle pain, so the DON requested an order for an x-ray which was obtained on 10/29/24 and was negative for fracture. She continued to explain that when she investigated the fall, she had NA #2 explain and demonstrate what happened and the NA indicated when she rolled Resident #57 over onto her side the NA kept her left hand on the Resident's hip and when she removed the brief the Resident rolled off the bed and onto the floor. The DON stated Resident #57 was alert and oriented and told NA #2 that she could do the Resident by herself, but the DON stated she felt that because Resident #57 had poor lower trunk control related to her diagnosis of Fredrick's Ataxia and with the

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momentum of being turned to her side, she could have kept on rolling. The DON stated in retrospect NA #2 should have obtained assistance from another staff member since it was the NA's first-time taking care of Resident #57.

2. Resident #8 was admitted to the facility on 06/27/14 with diagnoses that included Alzheimer's disease, anxiety, major depressive disorder, and adult failure to thrive.

A review of Resident #8's quarterly Minimum Data Set assessment dated 03/08/24 revealed her cognition was severely impaired with no delusions, behaviors, or rejection of care. Resident #8 was coded as having wandering behaviors daily. Resident #8 required supervision with mobility and was coded as using a manual wheelchair for mobility.

A review of Resident #8's care plan that was last reviewed on 08/01/24 revealed Resident #8 being at risk for wandering behaviors due to dementia. Interventions included to assess for elopement risk, distract Resident #8 from wandering by offering pleasant distractions, and to attempt to identify pattern of wandering and intervene as appropriate.

A review of facility incident and accident logs revealed a report dated 03/11/24 that indicated Resident #8 had obtained a bottle of wound cleanser and ingested an unknown amount. Per the incident report, Resident #8 was assessed along with telephone calls made to her representative, the on-call physician, and poison control. The report stated that Resident #8 was placed on observation and with no negative side

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effects observed. The report also indicated that Resident #8's confused cognition and wandering behaviors contributed to the incident.

Review of Resident #8's progress notes revealed a note dated 03/11/24 that read: "At approximately [10:15] Resident [#8] picked up a bottle of wound cleaner off of the treatment care and opened it up and drank an unmeasurable amount. Staff immediately obtained the cleaner from the resident and obtained vital signs (blood pressure 141/69, pulse 71, oxygen saturation 98%, respirations 16, and temperature 98.5 [degrees Fahrenheit]. This nurse immediately called on-call clinicians and spoke with physician whom stated to call poison control. This nurse then called poison control ... and informed them of the situation. She gave orders to give [Resident #8} one or two sips of water only and give nothing else for one hour and to closely observe [Resident #8] for any drooling, trouble swallowing, or blisters in the mouth or throat. If none of those symptoms occurred after one hour, to go ahead and give one or two more sips of water and resume regularly scheduled food/drinks and medications. If [Resident #8] does exhibit any of the above listed signs and symptoms, then she needs to be sent to the Emergency Room. This nurse gave detailed instructions to staff and staff are following clinician's instructions." The progress note was written by Nurse #4.

Review of the facility's safety data sheet (SDS) for the wound cleanser that was ingested by Resident #8 revealed the following instructions if accidentally ingested: "Ingestion - [look for] nausea, vomiting, and diarrhea. Drink water."

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	345329	A. BUILDING ______ B. WING ______	C 12/17/2024

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GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(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 689	Continued From page 36 An interview with Nurse #4 on 12/13/24 at 12:17 PM revealed he was familiar with Resident #8 and described her as very confused with aimless wandering behaviors. He also stated he remembered the incident and stated that two, now unknown, nurse aides came to him that evening with Resident #8 and a bottle of wound cleanser and informed him Resident #8 had ingested an unknown amount of wound cleaner. Nurse #4 stated he immediately assessed Resident #8 and obtained her vitals and did not believe there was anything out of the normal. He continued, stating that he called the on-call physicians who informed him to contact poison control. Poison control suggested that he closely monitor Resident #8 for any vomiting, nausea or the development of blisters in Resident #8's mouth and throat. He stated he then contacted the Director of Nursing and Resident #8's responsible party. Nurse #4 stated he monitored Resident #8 closely for the rest of his shift and did not note any nausea, vomiting, or blisters. He stated when he observed the wound cleanser bottle it did not appear to have much missing and estimated that the bottle was "almost full". Nurse #4 reported he was informed that Resident #8 had obtained the bottle of wound cleanser from the wound treatment cart which was kept at the end of a hall near the nurse's station. He stated it was routine for the wound cleanser not to be locked on the wound cart and was either stored in a side pocket or on top of the wound cart. Nurse #4 also reported that, to his knowledge, Resident #8 never had to receive additional medical treatment, in house, or at the hospital due to the ingestion of the wound cleanser. He reported that he had not seen Resident #8 attempt to ingest non-food items before or since the incident.	F 689		

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F 689	Continued From page 37	F 689		

Attempts were made to identify and speak to the unknown nurse aides that brought the incident to Nurse #4's attention but those attempts were unsuccessful.

An interview with the Wound Nurse on 12/11/24 at 2:33 PM revealed she did not know anything about Resident #8 ingesting wound cleanser. She stated if the wound cleanser was ingested it could cause some gastrointestinal discomfort, nausea, and/or vomiting. She stated she was aware Resident #8 had wandering behaviors and admitted to knowledge of Resident #8 having "touched things on the cart" but denied knowledge of Resident #8 taking anything off of the cart and attempting to or actually ingesting it. The Wound Nurse reported she typically kept wound cleanser on the cart and available for other staff when she was not in the facility. The Wound Nurse reported she stored the wound cleanser either on top of her cart or in a side pocket of the wound treatment cart and not locked away inside the cart.

An observation of the wound treatment cart on 12/12/24 at 1:37 PM revealed it was at the end of a hall outside of a resident's room. The room was posted as being on enhanced barrier precautions and the wound cart was outside the room, with the door closed. An observation of the wound cart revealed a bottle of wound cleanser sitting on top of the wound cart with the top unscrewed. There were no observed residents around the wound cart.

An interview with the Director of Nursing on 12/12/24 at 1:52 PM revealed she was familiar with Resident #8 and that she was severely

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F 689	Continued From page 38 cognitively impaired and had wandering behaviors. She stated in March, she was made aware of an incident by Nurse #4 regarding Resident #8 ingesting an unknown amount of wound cleanser. She stated poison control was contacted but reported she did not believe they instructed the staff to "do a whole lot". She indicated Resident #8 was monitored and given a few sips of water. The Director of Nursing reported Resident #8 had no adverse reaction to ingesting the wound cleanser. She reported the administrative staff discussed the incident in their interdisciplinary team meeting but could not recall if they implemented any additional care plan interventions or policies to help keep the incident from happening again. She stated wound cleanser should always be kept locked away to prevent residents from accessing it, and that nothing should be stored in the side pockets or on top of the wound treatment cart. An interview with the Medical Director on 12/11/24 at 2:33 PM revealed he had taken over as the medical director in August and was not aware of the Resident #8 ingesting wound cleanser. He reported there was always a potential concern with a resident ingesting wound cleanser and stated he would expect the staff to closely monitor the resident post ingestion for metabolic and other issues which included vomiting, diarrhea, or changes in their general condition. He did report small doses would not necessarily be concerning.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		1/8/25

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F 695	Continued From page 39 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to obtain an order for the use of supplemental oxygen and post oxygen cautionary signage for 1 of 1 resident (Resident #75) reviewed for respiratory care. Findings included: Resident #75 was admitted to the facility on 09/30/24 with diagnoses that included left lower lobe pneumonia, sepsis and pleural effusion. The admission Minimum Data Set (MDS) assessment dated 10/07/24 revealed Resident #75 was cognitively intact. A review of Resident #75's medical record revealed there was no order for supplemental oxygen. A review of Resident #75's Medication Administration Record (MAR) for September 2024, October 2024, November 2024 and December 2024 indicated there was no order for supplemental oxygen administration on the records. On 12/09/24 at 10:23 AM an observation and interview were conducted with Resident #75 who was lying in bed and wearing continuous oxygen	F 695	1. Resident # 75 was noted to be using oxygen therapy, she did not have an oxygen order, sign on the outside of her door nor care plan reflecting oxygen therapy. An order was obtained for oxygen therapy, sign was placed outside the door notifying oxygen in use, and care plan was updated on 12/10/2024. 2. An Audit was conducted by DON/designee on 12/30/2024, verifying that residents who are using oxygen therapy have an order for oxygen therapy, oxygen sign outside of door and a care plan to reflect need for oxygen therapy. No further discrepancies were noted. 3. On 01/07/2025, education was provided to nursing staff reviewing the components needs for oxygen therapy by the DON. 4. The Director of Nursing or designee will conduct Quality Assurance/ Process Improvement monitoring on F 695 to ensure that residents using oxygen therapy have all the needed components (MD order, sign outside the door and care plan) 3x/week for 8 weeks, then weekly for 4 weeks, then monthly for 6 months.	

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F 695	Continued From page 40 at 1.5 liters via nasal cannula. The Resident reported she has worn oxygen since her admission to the hospital prior to her admission to the facility and wore it all the time except when she was eating. There was no oxygen cautionary sign posted on or about the Resident's door. An observation was made on 12/10/24 at 9:39 AM of Resident #75 wearing continuous oxygen at 1.5 liters via nasal cannula. There was no oxygen cautionary sign posted at the Resident's door. On 12/10/24 at 1:23 PM during an interview with Nurse Aide (NA) #1, she explained that only the nurses were responsible for initiating oxygen, changing the rate of oxygen flow and checking the residents' oxygen saturation. The NA stated she was not sure who was responsible for posting the oxygen signage on the residents' door. During an interview with Nurse #1, on 12/10/24 at 2:17 PM, the Nurse explained that Resident #75 had been on continuous oxygen since she has been on his hall, and he checked her oxygen saturation level every day. He stated he had not checked it yet today (12/10/24) but the check for 12/09/24 was 96%. He stated he automatically checked the oxygen saturation while on his rounds because he knew the Resident wore oxygen. When Nurse #1 was asked how much oxygen Resident #75 should be on the Nurse referred to the MAR and realized there was no order for oxygen on the MAR. Nurse #1 then looked to see if Resident #75 had an order for supplemental oxygen, but he could not find the order. The Nurse explained that the nurse who admitted Resident #75 to the facility or initiated the oxygen was responsible for starting the	F 695	The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly until committee determines substantial compliance has been met and recommends moving to quarterly monitoring. 5. 01/08/2025	

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F 695	Continued From page 41	F 695		

oxygen and posting the cautionary signs on the residents' door and if the Resident did not have an order for oxygen but was wearing oxygen the nurse should have addressed that with the physician and obtain an order for the oxygen.

During an interview with the Director of Nursing (DON) on 12/11/24 at 10:38 AM, the DON explained that there should be an order for supplemental oxygen administration with the amount of liter flow included in the order. The DON also stated the person who initiated the oxygen should have posted the cautionary sign on the door. She also indicated the department manager should have made sure the oxygen sign was posted on the door when they made their daily rounds.