STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 02/24/25 through 02/27/25. Additional interviews were conducted on 03/03/25 and 03/05/25, therefore, the exit date was changed to 03/05/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 0NLW11.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted 02/24/2025 through 02/27/2025. Additional interviews were conducted on 03/03/25 and 03/05/25, therefore, the exit date was changed to 03/05/25. Event ID# 0NLW11. The following intakes were investigated NC00208543, NC00210181, NC00211177, NC00211715, NC00213004, NC00213956, NC00214615, NC00215522, NC00215660, NC00215711, NC00216297, NC00216431, NC00216606, NC00218692, NC00222568, NC00222821, NC00224777, NC00224870, NC00225336, NC00226453. 4 of the 61complaint allegations resulted in deficiency. Immediate jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J); the IJ began 06/25/2024 and was removed 07/03/2024. The tag F689 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		3/18/25

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

Electronically Signed | 03/26/2025

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F 582	Continued From page 1	F 582		

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any

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F 582	Continued From page 2 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 2 of 3 residents (Resident #113 and Resident #302) reviewed for beneficiary notification. The findings included: a. Resident #113 was admitted to the facility on 8/20/24. Medicare Part A services began on 9/01/24. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was issued on 9/27/24 to Resident #113's Responsible Party (RP) which explained Medicare Part A coverage for skilled services would end on 10/01/24. Resident #113 remained in the facility. A review of the medical record revealed a CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (ABN) was not provided to	F 582	For the residents noted to be affected, if the resident is still in the facility, the business office manager provided a copy of the Advanced Beneficiary Notice (ABN) was provided to them even if they had not appealed the decision to end Medicare Part A benefits. This was completed on 3/5/25 by the business office manager. All residents from 1/1/2024 to the current were audited to identify any Medicare Part A beneficiary(s) that remained in the facility following a Medicare stay whose benefit period ended as determined by the facility and had days left. Those identified were presented with a copy of an Advanced Beneficiary Notice (ABN) even though they had not appealed the decision. This was completed by the business office manager on 3/18/2025. On 2/28/2024, the regional business office manager retrained the business office manager on the requirements to issue	

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F 582	Continued From page 3 Resident #113 or their RP. b. Resident #302 was admitted to the facility on 11/02/24. Medicare Part A services began on 11/04/24. A review of the medical record revealed a CMS-10123 NOMNC was issued on 12/11/24 to Resident #302's RP which explained Medicare Part A coverage for skilled services would end on 12/13/24. Resident #302 remained in the facility. A review of the medical record revealed a CMS-10055 ABN was not provided to Resident #302 or their RP. An interview was conducted with the Business Office Manager (BOM) on 2/26/25 at 2:55 PM. The Business Office Manager confirmed Resident #113 and Resident #302 remained in the facility after their Medicare Part A benefits ended and a CMS-10123 NOMNC was issued to their RPs however a CMS-10055 ABN was not provided. The BOM indicated she had been working at the facility for approximately 1 year and was trained by the Regional Business Office Manager. She stated she was trained to issue the CMS-10123 NOMNC when a resident's Medicare Part A benefit was ending and they remained in the facility, but she was not aware the CMS-10055 ABN was also required. A phone interview was conducted with the Regional Business Office Manager on 2/27/25 at 8:08 AM. He stated when a resident's Medicare Part A benefit was ending the BOM issued the CMS-10123 NOMNC to the resident and/or the RP, but he was not aware if the resident remained in the facility that a CMS-10055 ABN	F 582	Advanced Beneficiary Notice (ABN) on a Medicare beneficiary whose benefits stop as a result of the facility determining they no longer met Medicare guidelines. The Advanced Beneficiary Notice (ABN) should be issued at the time of the Notice of Non-Coverage for Medicare Coverage. To ensure on-going compliance, the administrator will audit all Notices for 3 weeks and then up to 2 Notices a week (if available) for 2 weeks and then as needed for on-going compliance to ensure the Advanced Beneficiary Notice (ABN) is included with the Notice of Non-Coverage. The results of these audits will be brought to the QA Committee by the administrator. The QA Committee will monitor the outcomes these audits and the effectiveness of this plan of correction.	

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F 582	Continued From page 4 was also required. An interview with the Administrator on 2/27/25 at 3:00 PM revealed when a resident's Medicare Part A benefit was ending, and they remained in the facility a CMS-10123 NOMNC and CMS-10055 ABN should be issued to the resident and/or the RP.	F 582		
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.	F 657		3/5/25

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F 657	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to update a resident's care plan after a resident had an indwelling urinary catheter placed for 1 of 3 residents (Resident #26) reviewed for urinary catheters. The findings included: Resident #26 was admitted to the facility on 5/30/2022 with diagnoses which included obstructive uropathy (condition where urine flow is blocked). A physician's order dated 2/4/2025 revealed Resident #26 was ordered to have an indwelling urinary catheter with a diagnosis of obstructive uropathy. A quarterly Minimum Data Set (MDS) dated 2/7/2025 revealed Resident #26 was cognitively intact and had an indwelling urinary catheter. A care plan for Resident #26 dated 2/22/2025 did not contain a focus, goal, or interventions related to an indwelling urinary catheter. An observation was conducted on 2/24/2025 at 11:35 am. Resident #26 was observed in bed on his left side with catheter tubing visible. Resident #26 had a catheter with a leg bag attached to his right leg. An interview was conducted on 2/26/2025 at 3:01 pm with the MDS Nurse. The MDS Nurse stated she was responsible for completing MDS assessments and updating resident's care plans. The MDS Nurse stated indwelling urinary	F 657	For the resident affected, the care plan was updated on 2/26/2025 by the corporate Regional Assessment Coordinator. For the residents with the potential to be affected, care plans for all residents were reviewed on 2/26/2025 by the Regional Assessment Compliance Coordinator. No other residents were identified as being affected. To ensure not other residents are affected, the corporate Regional Assessment Compliance Coordinator educated the facility MDS Coordinator regarding updating care plans to reflect foley catheters. This training was held on 2/27/25. To ensure on-going compliance, the Regional Assessment Compliance Coordinator will audit 5 Care Plans weekly x 4 weeks, then 3 care plans weekly x 2 weeks, and 1 care plan weekly x 2 weeks for accuracy. The audits will be extended if needed to assure compliance. The Administrator will be responsible for bringing the Care Plan audits to the monthly Quality Assurance Committee meeting monthly x 3 months. Audits will continue if the QA Committee deems this is necessary.	

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F 657	Continued From page 6 catheters were supposed to be care planned. The MDS Nurse acknowledged Resident #26 did not have a care plan for an indwelling urinary catheter and reported he should have been care planned for the indwelling urinary catheter. The MDS Nurse stated it must have been overlooked. An interview was conducted on 3/5/2025 at 8:51 am with the Director of Nursing (DON). The DON stated the MDS Nurse was responsible for updating the care plan. The DON stated urinary catheters were to be care planned and she stated she was unsure why Resident #26's care plan had not been updated. The DON stated Resident #26's care plan should have been updated within 14 days of the catheter being placed.	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, Medical Director, and Wound Care Physician interviews, the facility failed to recognize a	F 686	On 2/27/25 the director of nursing (DON) and wound care nurse updated Resident #59 family on her continued decline, end	3/25/25

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F 686	Continued From page 7	F 686		

developing pressure ulcer, implement preventative measures, provided treatments as ordered, and consistently measure a resident's wounds on a weekly basis. The facility failed to have a Wound Care Provider evaluate residents at the facility when the Wound Care Physician was on vacation for 1 of 3 residents (Resident #59) reviewed for facility acquired pressure ulcers. On 11/20/24 Resident #59 developed discoloration to the coccyx area which developed to unstageable pressure ulcer on 12/06/24 that required a debriding agent (removal of dead tissue). The wound further required antibiotic treatment for infection, treatment using non-contact, non-thermal, low frequency ultrasound and physical debridement of the wound on 02/19/25.

The findings included:

Resident #59 was admitted to the facility on 10/31/19 with diagnoses which included diabetes and Parkinsonism.

Review of a care plan initiated on 07/18/22 and last updated on 01/26/25 read in part, Resident #59 is at risk for pressure ulcer development due to bladder incontinence and decreased mobility. Resident #59 refuses to be turned and repositioned at times. The interventions included: assist with turning and repositioning, bilateral soft heel protectors worn while in bed as tolerated, follow Medical Doctors orders for skin care and treatments, keep skin clean and dry, pillow under legs while in bed, the resident needs a pressure reducing mattress on bed, the resident needs pressure relieving cushion in wheelchair, and weekly skin checks. All the interventions were added on 07/18/22. Weekly treatment

of life signs as evidenced by diagnosis of skin failure. Hospice was recommended for additional supportive care. On 2/28/25 the family met with Hospice and elected to contract with Hospice for End of Life Care.

On 2/28/25 the DON met with the Wound Care Team (comprised of two trained wound nurses) to review omissions of wound care dressing changes. The DON educated the wound care team on the expectation of signing eTAR upon completion of wound care per licensed provider's order or indicate any refusal as per facility protocol.
On 3/5/25 the DON educated the Wound Care Team on expectations of wound care being performed per state & federal guidance and facility protocol. This education included performing resident wound care daily, ensuring wound care provider is rounding in the facility weekly or the DON, Registered Nurse (RN) supervisor, Staff Development Coordinator (SDC), or the Infection Preventionist Nurse (IPN) assesses, and measures facility wounds weekly and/or newly obtained/admitted wounds upon day noted. This education also included notification to the facility licensed provider of any worsening wounds should the Wound Care Provider not be available.

Beginning 2/28/25 the wound care team will meet with the DON, nurse manager, or the facility administrator to review wound care and wound care dressing changes via the eTAR to ensure all wound care has been performed for the day and

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F 686	Continued From page 8 documentation includes measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations added on 03/11/23. A Braden Scale dated 8/13/2024, completed by Nurse #2, revealed Resident #59 was at risk for developing a pressure ulcer. A skin assessment dated 11/13/2024 indicated Resident #59 had no note skin issues. A skin assessment completed by Nurse #2 dated 11/20/2024 indicated Resident #59 had discoloration to the coccyx area with treatment initiated. No further description or measurements were noted. A physician's order dated 11/20/2024 revealed Resident #59 was to have her sacrum/coccyx area cleansed, patted dry, a hydrocolloid (type of dressing) dressing applied three times a week everyday shift for wound care. A physician's order dated 11/26/2024 revealed Resident #59 was to have her sacrum cleansed, patted dry, a hydrocolloid dressing applied every Tuesday, Thursday, and Saturday for wound care. A skin assessment dated 11/27/2024 indicated Resident #59 had discoloration to the coccyx area and softness to heels. No further description or measurements were noted. The November 2024 Treatment Record (TAR) revealed Resident #59 had a hydrocolloid dressing applied as ordered from 11/20/24 through 11/30/24.	F 686	there are no omissions noted. Any identified omissions or uncompleted wound care will be corrected/performed prior to the wound team leaving for the day. Beginning 2/28/25 the Wound Care Team will notify the DON, SDC, IPN, or the RN supervisor of any worsening or newly obtained admitted wounds for assessment. On 3/16/25 the DON initiated a Wound Care communication binder at each nurse station for notification of new wound areas. The identifying nurse will initiate a wound treatment for any new skin areas using the facility protocol and notify the wound care team via the wound care binder or verbally if the wound care team is present in the facility. On 3/16/25 the DON and the SDC educated the nursing staff on the updated wound care/notification process On 3/16/25 the SDC added this education to the new hire packet and agency/contract nurse and medication aide packet. After 3/26/2025, no Contracted Agency/Facility Nursing Staff will be allowed to work until the education is completed on Wound Care communication binder at each nurse station for notification of new wound areas. The identifying nurse will initiate a wound treatment for any new skin areas using the facility protocol and notify the wound care team via the wound care binder or verbally if the wound care team is present in the facility. Beginning 2/28/25 the wound care team will meet with the DON or Unit Manager to review wound care and wound care dressing changes via the eTAR to ensure	

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F 686	Continued From page 9 A skin assessment dated 12/4/2024 indicated Resident #59 had discoloration to the sacrum area and softness to heels. No further description or measurements were noted. The December 2024 Treatment Administration Record (TAR) revealed the wound care to the sacrum was not initialed as provided on 12/3/2024, 12/5/2024, 12/7/2024, 12/15/2024 or 12/17/2024. The remainder of the days in December 2024 were documented as completed per the Physician order. A wound care provider note dated 12/6/2024 revealed Resident #59 was assessed and had a coccyx wound (with a duration of greater than 21 days) which measured 1.2 centimeters (cm) x 0.5 cm x 0.2 cm with a surface area of 0.60 cm. A moderate amount of serous drainage (watery pale-yellow fluid) with 100% thick adherent devitalized (dead) necrotic tissue present. Debridement (removal of dead tissue) was refused by Resident #59. The Wound Care Physician recommended offloading of the wound, group-2 (air, alternating pressure) mattress, zinc 220 milligrams (mg) once daily for 14 days, vitamin C 500 mg twice daily, a multivitamin once daily, to upgrade offloading chair cushion, apply alginate calcium daily for 30 days, apply Santyl (ointment used for removal of dead tissue) daily for 30 days, and to cover with a gauze island border dressing for 30 days. Review of a physician order dated 12/7/2024 read, Air mattress. Zinc 220 milligrams once daily for 14 days, vitamin C 500 mg twice daily, a multivitamin once daily, to upgrade offloading chair cushion.	F 686	wound care has been performed for the day according to licensed provider orders and there are no omissions noted to avoid worsening wounds daily x4 weeks, then 3x weekly for 4 weeks, then weekly for 4 weeks to ensure compliance of wound care dressing changes via the eTAR to ensure wound care has been performed for the day according to licensed provider orders and there are no omissions noted to avoid worsening wounds Beginning 3/26/2025 the DON will report the findings of the monitoring: wound care dressing changes via the eTAR to ensure wound care has been performed for the and there are no omissions noted. Beginning the month of April 2025 and continuing for 3 months, the DON will report the findings of the monitoring: wound care dressing changes via the eTAR to ensure wound care has been performed for the day according to licensed provider orders and there are no omissions noted to avoid worsening wounds monthly to of Quality Assurance (QA) Committee. The QA Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained.	

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F 686	Continued From page 10	F 686		

Review of the December 2024 Medication Administration Record (MAR) revealed that the Zinc, Vitamin C, and multivitamin were administered as ordered.

A wound observation assessment dated 12/8/2024, completed by Wound Care Nurse #1, revealed Resident #59 had acquired an unstageable pressure ulcer on 12/5/2024 to her coccyx. Necrotic tissue present (percentage not documented). The wound was measured at 1.2 cm x 0.5 cm x 0.2 cm with no documented drainage. The Wound Care Physician was notified on 12/6/2025 and Resident #59 was started on Santyl, alginate (used to absorb drainage), and an island (an adhesive dressing that absorbs wound drainage) dressing.

A physician's order dated 12/8/2024 revealed Resident #59 was to have her coccyx cleansed with Dakins (topical antiseptic), patted dry, Santyl applied, calcium applied, and covered with a border gauze dressing one time a day for wound healing.

A wound care provider note dated 12/11/2024 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 26 days) which measured 1.0 cm x 0.4 cm x 0.4 cm with a surface area of 0.40 cm. A moderate amount of serous drainage with 50% thick adherent devitalized necrotic tissue present and 50% viable subcutaneous tissue present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound (a painless, non-contact ultrasound wave delivered through a saline mist to aid in wound healing). There were no changes to the treatment plan.

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The Wound Care Physician recommended checking Resident #59's prealbumin.

A wound care provider note dated 12/18/2024 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 33 days) which measured 2.0 cm x 0.7 cm x 0.5 cm with a surface area of 1.40 cm. A moderate amount of serous drainage with 10% thick adherent devitalized necrotic tissue present and 90% granulation tissue present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. There were no changes to the treatment plan.

Review of Resident #59#'s medical record revealed no wound assessment, wound measurements, or Wound Care provider visits from 12/19/202 through 12/31/24 due to the Wound Care Provider being unavailable.

A significant change Minimum Data Set (MDS) dated 12/19/24 revealed Resident #59 was severely cognitively impaired with no behaviors or rejection of care. Resident #59 require moderate assistance with toileting, bathing, upper and lower body dressing, and personal hygiene. The MDS indicated Resident #59 was at risk for developing pressure ulcers and was noted to have 1 unstageable pressure ulcer and received application of an ointment and dressing. The MDS indicated that Resident #59 was not receiving hospice services.

A laboratory report dated 12/20/24 indicated Resident #59's prealbumin was 12. Normal range was 18-38. (Low albumin levels are associated with malnutrition and protein deficiency and can

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result in prolonged wound healing).

The January 2025 TAR revealed the wound treatment to Resident #59's coccyx was not initialed as provided on 1/7/25, 1/8/25, 1/12/25, 1/15/25, 1/16/25, 1/21/25, 1/22/25, 1/23/25, 1/24/25, and 1/27/25 (10 of the 31 days).

A wound care provider note dated 1/1/2025 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 47 days) which measured 3.5 cm x 1.1 cm x 0.7 cm with a surface area of 3.85 cm. A moderate amount of serous drainage with 10% slough, 80% granulation tissue, and 10% fascia present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. There were no changes to the treatment plan.

A wound care provider note dated 1/8/2025 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 54 days) which measured 3.1 cm x 0.8 cm x 0.7 cm with a surface area of 2.48 cm. A moderate amount of serous drainage with 20% slough and 80% granulation tissue present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. There were no changes to the treatment plan.

A wound care provider note dated 1/15/2025 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 61 days) which measured 3.1 cm x 1.0 cm x 0.5 cm with a surface area of 3.10 cm. A moderate amount of serous drainage with 10% slough and 90% granulation tissue present. Debridement

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was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. There were no changes to the treatment plan.

A wound care provider note dated 1/22/2025 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 68 days) which measured 2.7 cm x 0.6 cm x 0.7 cm with a surface area of 1.62 cm. A moderate amount of serous drainage with 10% slough and 90% granulation tissue present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. There were no changes to the treatment plan.

A wound care provider note dated 1/29/2025 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 75 days) which measured 2.3 cm x 0.6 cm x 0.5 cm with a surface area of 1.38 cm. A moderate amount of serous drainage with 20% slough and 80% granulation tissue present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. There were no changes to the treatment plan.

The February 2025 TAR revealed there was no documented wound care for Resident #59 on 2/3/25, 2/17/25, 2/19/25, and 2/26/25 (4 of 26 days reviewed).

A wound care provider note dated 2/5/2025 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 82 days) which measured 1.3 cm x 0.6 cm x 0.5 cm with a surface area of 0.78 cm. A moderate

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amount of serous drainage with 10% slough and 90% granulation tissue present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. There were no changes to the treatment plan.

A wound care provider note dated 2/12/2025 revealed Resident #59's was assessed and had a coccyx wound (with a duration of greater than 82 days) which measured 2.2 cm x 0.9 cm x 1.1 cm with a surface area of 1.98 cm. A moderate amount of serous drainage with 10% slough, 80% granulation tissue and 10% subcutaneous tissue present. Debridement was attempted but aborted due to pain. The wound was treated with non-contact, non-thermal, low frequency ultrasound. The treatment plan was changed to apply wet to moist Dakins dressing once daily for 30 days, apply a sterile gauze sponge once daily, apply Santyl once daily, and cover with a gauze island border dressing.

A physician's order dated 2/14/2025, and discontinued on 2/17/2025, revealed Resident #59 was to have her coccyx cleansed with Dakins, patted dry, Santyl applied, and staff were to use plain packing strips to pack the wound and cover with a border gauze dressing every day shift for wound healing.

A physician's order dated 2/18/2025, and discontinued on 2/19/2025, revealed Resident #59 was to have her coccyx cleansed with Dakins, patted dry, Santyl applied, add wet to moist dressing over the Santyl, and cover with a border gauze dressing every day shift for wound healing.

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A wound care provider note dated 2/19/2025 revealed Resident #59's coccyx wound measured 4.0 cm x 5.7 cm x 0.8 cm with a surface area of 22.80 cm. An open ulceration area of 18.24 c. A moderate amount of serous drainage with 10% thick adherent devitalized necrotic tissue, 40% granulation tissue, 30% subcutaneous tissue/muscle/facia, and 20% intact normal color skin. A surgical excisional debridement procedure was performed to remove necrotic tissue and establish the margins of viable tissue. 2.28 cm of devitalized tissue and necrotic muscle level tissues were removed at a depth of 0.9 cm and healthy bleeding tissue was observed.

The Wound Care Physician recommended Meropenem (antibiotic) 1 gram intravenously every 8 hours for 10 days.

A physician's order dated 2/20/2025, and discontinued on 2/24/2025, revealed Resident #59 was to have her coccyx cleansed with Dakins, patted dry, wet to moist dressing applied, alginate applied around the wound, and covered with a border gauze dressing.
A physician's order dated 2/21/2025 revealed Resident #59 was ordered linezolid (used to treat infections) 20 milliliters by mouth twice a day for seven days for a wound infection. The order was discontinued on 2/22/2025.

Review of the February 2025 TAR revealed Resident #59 received one dose of the linezolid before it was discontinued.

A physician's order dated 2/22/2025 revealed Resident #59 was ordered penicillin V potassium 500 mg by mouth twice a day for 10 days for a positive wound culture.

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Further review of the February 2025 TAR revealed Resident #59 received the penicillin V potassium as ordered.

An interview was conducted on 2/25/2025 at 2:16 pm with Wound Care Nurse #1. Wound Care Nurse #1 stated wound care nurses were present at the facility 7 days per week and did treatments. Wound Care Nurse #1 stated prior to Resident #59's wound developing, she was being turned and repositioned every two hours. Wound Care Nurse #1 stated Resident #59 developed an area of discoloration on 11/20/2024, that was observed by Nurse #2. Wound Care Nurse #1 stated at that time Resident #59 was placed on a hydrocolloid dressing. Wound Care Nurse #1 stated on 12/5/2024 Resident #59 developed an unstageable pressure ulcer. Wound Care Nurse #1 verified Resident #59 was placed on a pressure mattress on 12/7/2024. Wound Care Nurse #1 stated the Wound Care Physician came to the facility every Wednesday to round on his residents. Wound Care Nurse #1 stated on 2/17/2025 Resident #59's wound looked different, and she asked the Director of Nursing (DON) to come and assess Resident #59 at which time a wound culture was obtained, which resulted as Vancomycin-resistant enterococci (VRE, an antibiotic-resistant bacteria). Wound Care Nurse #1 stated the Wound Care Physician saw Resident #59 on 2/19/2025. Wound Care Nurse #1 reported Resident #59 did not refuse wound care treatments.

An interview was conducted on 2/25/2025 at 2:24 pm with the DON. The DON stated Resident #59 was incontinent of bowel and bladder, spent a lot of time in bed (per Resident #59's request) and

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was dependent on staff for most care. The DON verified an area of discoloration was noted by Nurse #2 on 11/20/2024, with no measurements or other description, and stated Resident #59 was started on a hydrocolloid dressing. The DON stated Resident #59 was not evaluated by the Wound Care Physician that week because he was out of town for Thanksgiving. The DON stated Resident #59 was first seen by the Wound Care Physician on 12/6/2024 at which time the wound was unstageable and was placed on Santyl, alginate, and an island dressing. The DON stated Resident #59's wound had deteriorated over time. The DON stated on 2/17/2025 she was asked by Wound Care Nurse #1 to assess Resident #59's wound on her coccyx at which time she stated it appeared to have worsened and stated it "looked like it had infection to it."

A wound care observation was conducted on 2/26/2025 at 11:51 am with Wound Care Nurse #1 and Wound Care Nurse #2. When Resident #59 was turned onto her right side she was observed to have facial grimacing, her body tensed up, and she began to guard. Resident #59's wound was observed to be larger than a fist, black, brown, and tan in color with excoriation noted to the surrounding skin and was covered with dressing dated 02/25/25 that was completely saturated with bloody drainage with blood noted on the brief. Wound Care Nurse #1 and #2 did not measure the wound. When the dressing was removed, it was noted to have a foul-smelling odor coming from the wound. When Wound Care Nurse #1 and Wound Care Nurse #2 attempted to clean the wound, Resident #59 was unable to tolerate her scheduled dressing change, by crying, grimacing, and saying to stop.

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The wound was covered with an island dressing for protection.

Further attempts to interview Resident #59 on 02/26/25 and 02/27/25 were unsuccessful.

An interview was conducted on 2/26/2025 at 2:49 pm with Nurse #2. Nurse #2 stated he frequently cared for Resident #59. Nurse #2 stated on 11/20/2024 he observed an area of discoloration to Resident #59's coccyx area. Nurse #2 stated it looked like she had laid on one area for a long time. Nurse #2 stated it was blanchable on 11/20/2024. Nurse #2 stated he did not measure Resident #59's area of discoloration because they do not obtain measurements unless there was an open wound. Nurse #2 was unsure if he notified the wound care nurses on 11/20/2024 of Resident #59 having discoloration to her coccyx. Nurse #2 stated she was placed on a hydrocolloid dressing and stated the wound had not gotten any better. Nurse #2 stated the wound care nurses were responsible for wound care.

An interview was conducted on 2/27/2025 at 11:12 am with Wound Care Nurse #2. Wound Care Nurse #2 stated she and Wound Care Nurse #1 rounded on residents daily, and weekly with the wound care provider, performed dressing changes, and measured wounds for residents not seen by the facility's Wound Care Physician. Wound Care Nurse #2 stated on 12/6/2024 Resident #59 had a small wound that changed quickly. Wound Care Nurse #2 stated a wound culture was obtained on 2/17/2025, which resulted as many gram-positive cocci, many gram-negative rods, light growth of enterococcus faecalis, and Vancomycin resistant enterococcus and was susceptible to both Linezolid and

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penicillin. Wound Care Nurse #2 stated the Wound Care Physician had evaluated Resident #59 on 2/19/2025 and stated she was not sure why the Meropenem had not been ordered every 8 hours as mentioned in his note. Wound Care Nurse #2 stated the Medical Director, and the Wound Care Provider were made aware of the final results of the wound culture obtained on 02/17/25 at which time Resident #59 was started on antibiotics. Wound Care Nurse #2 stated Resident #59 was unable to tolerate wound care on 2/26/2025 due to pain, she stated she had not known of any other time that Resident #59 had refused wound care. Wound Care Nurse #2 stated she was not sure why there was nothing documented for 2/26/2025. Wound Care Nurse #2 stated it should have been documented as a refusal. Wound Care Nurse #2 stated Resident #59 had not refused wound care to her knowledge and stated she was not sure why there was no documentation that wound care was performed or refused on the TAR in December 2024, January 2025, and February 2025 for the days it was not initialed as completed.

A telephone interview was conducted on 3/3/2025 at 4:03 pm with the Wound Care Physician. The Wound Care Physician stated Resident #59 had a pressure ulcer that he had treated for the past two and a half months. The Wound Care Physician stated initially the wound was progressing well until approximately two or three weeks ago at which point it changed dramatically and looked completely different. The Wound Care Physician stated he reviewed Resident #59's treatment plan at that time, ensured she was on an air mattress and had a gel cushion for her wheelchair. The Wound Care Provider stated it looked necrotic and had a foul odor. The

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Wound Care Physician stated he debrided the wound on 2/19/2025 and thought that Resident #59 had "skin failure" which indicated that it would not heal. The Wound Care Provider stated he had not seen Resident #59 for the past two weeks, since 2/19/2025, because he had been on vacation. The Wound Care provider stated the contracted wound care service would try to send someone to the building while he was on vacation or unavailable and verbalized that there was always a provider available by phone. The Wound Care Physician stated Resident #59's pain was "not bad" and acknowledged that when she had pain, he would stop and use ultrasound mist instead. The Wound Care Physician stated ultrasound mist was just as effective as the debridement.

A telephone interview was conducted on 3/4/2025 at 11:33 am with the Medical Director. The Medical Director stated he had collaborated with the Nurse Practitioners and the Wound Care Physician regarding Resident #59's antibiotics for the positive wound culture. The Medical Director stated it typically took 3-4 days to get a final wound culture result back from the lab with culture and sensitivity. The Medical Director stated he would not have started Resident #59 on an antibiotic prior, due to not knowing which antibiotic would be most appropriate.

A follow-up telephone interview was conducted on 3/5/2025 at 8:51 am with the DON. The DON stated prior to 12/7/2024, Resident #59 had not been on an air mattress. The DON stated Resident #59 had a prior wound to her coccyx previously that had healed greater than a year ago at which time she was on an air mattress, and when that wound had healed, Resident #59

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F 686	Continued From page 21 had been taken off an air mattress. The DON stated they do not place residents on an air mattress unless they have a stage 3 or 4 pressure ulcer. The DON stated in the absence of the Wound Care Provider, she assessed and measured his resident's wounds. The DON was unable to explain why there was no charted assessment or measurements for Resident #59's wound from 11/20/2024 through 12/5/2024, from 12/18/2024 through 1/1/2025, or from 2/19/2025 through 2/28/2025. The DON stated the contracted wound care service had offered to send a provider the week of 12/25/2024 and the week of 2/26/2025, but the times did not work well for the residents due to their meal schedules.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interview, Nurse Practitioner and Medical Director interview, the facility failed to ensure the necessary supervision was provided to a cognitively impaired resident to prevent an avoidable accident. On 06/25/24 Resident #79, who was known to have poor safety awareness, returned from an outing on the facility's transportation bus and was left unattended on the bus by three staff members. The front door of the	F 689	1. Address how corrective actions will be accomplished for those residents who have been affected by the deficient practice: On 06/25/24 the facility van returned to the facility following an outing with 4 residents, 3 staff and a volunteer. When the van returned to the facility, the Activities Director and volunteer exited the	3/5/25

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F 689	Continued From page 22 bus was left open. Resident #79 unbuckled her seatbelt and ambulated to the front of the bus exiting at the front stairs. The resident was wearing slip on shoes that came off, the resident lost her footing and experienced a fall from the bus steps, hitting her head and landing on her right side on the asphalt. On initial assessment, the resident sustained multiple injuries that included a right shoulder bone dislocation, skin tears to the upper and lower extremities, abrasions to the lower extremities and forehead, a bruise to the inner right back, a right tongue hematoma (collection of blood formed under the tongue), a cracked right front tooth, and a lump/hematoma to the right side of her head. Following the incident the resident experienced dizziness and vomited multiple times. She was assessed at the hospital with a left temporal subarachnoid hemorrhage (bleeding in the space below one of the thin layers that cover and protect the brain), right clavicle (collarbone) fracture, right humeral (long bone that runs from the shoulder to elbow) fracture and bilateral rib fractures. At a lower scope and severity of D, the facility failed to ensure a safe transfer in a mechanical lift for a resident (Resident #138) when Nurse Aide (NA) #2 transferred Resident #138 in a mechanical lift in an unsafe manner. The deficient practice affected 2 of 11 residents reviewed for supervision to prevent accidents (Resident #79 and Resident #138). Immediate jeopardy began on 06/25/24 when Resident #79 was left unattended on a transportation bus. She unbuckled herself and ambulated to the front of the bus exiting the stairs resulting in a fall. Immediate jeopardy was removed on 07/03/24 when the facility implemented a credible allegation of immediate	F 689	van to discard the waste. The Van Driver who is the only one trained to operate the lift exited the van to begin the unloading process in the lift area. The Activities Assistant remained in the van and instructed residents to remain seated and they would be unloaded starting at the back. The Activities Assistant then exited the van to assist the Van Driver who had opened the door. No staff were in the van, but the Van Driver and Activities Assistant were at the lift and within 60 inches of the resident. Resident #79 was seated closest to the staff, unbuckled herself, ambulated to the steps of the van and fell to the asphalt after being reminded by staff to stay seated. There were no staff members in the van at the time of the event, but staff were in speaking distance at the rear of the van. After being assessed, one of the resident's slippers were noted on the top step and the other was lower on the steps indicating she stepped on the back of her slipper which caused the fall. On 6/25/24, the affected resident, Resident # 79, was immediately assessed by the onsite nurse practitioner prior to her being moved. Upon the initial assessment, it was deemed the resident was safe to be transported into the facility where she was placed in bed and continued to be assessed. Emergency Medical Services (EMS) was notified to transport the resident to the hospital for additional tests and exams. On 7-5-2024, Resident #79 was readmitted to the facility.	

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F 689	Continued From page 23 jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example #2 is being cited a scope and severity of D. The findings included: 1. Resident #79 was admitted to the facility on 11/16/2022 with diagnoses of cerebrovascular accident (CVA), Non-Alzheimer's dementia and hemiplegia (paralysis or weakness on one side of the body) affecting the right dominant side. A fall risk evaluation dated 11/01/23 revealed Resident #79 scored a level 8, indicating she was at moderate risk for potential falls. The resident was noted to have a balance problem while standing and required the use of assistive devices such as a wheelchair. Resident #79's annual Minimum Data Set (MDS) assessment dated 03/26/24 revealed she was moderately cognitively impaired and required extensive assistance of one staff member for sit to stand transfers and chair to bed transfers. Resident #79 was coded under walking 10 feet as "not applicable". Resident #79 used a wheelchair as an assistive device and had no functional impairments with range of motion to the upper or lower extremities. She did not receive an anticoagulant during the assessment period. An interview conducted on 03/03/25 at 11:26 AM	F 689	2. How will the facility identify other residents having the potential to be affected by the same deficient practice: On 06/25/24 during her initial interview with the Van Driver, the Director of Nursing inquired if any other resident had fallen or had any other “near miss” on the van. No other residents were identified. On 6/26/24 the Interdisciplinary Team consisting of all department managers, Administrator and Director of Nursing met to review residents with outside appointments. They met to identify residents scheduled for transport through 7/6/24 using the medical record to identify residents that were unable to make their needs known, appropriately respond to direction, had a BIMS score less than 10, and those unable to comply with standard safety precautions. Identified residents will have increased supervision on their transport to and from the facility as well as proper footwear. Moving forward, the facility will conduct weekly reviews of all residents scheduled for transportation to ensure ongoing compliance with this protocol. In addition, residents must have safe and appropriate footwear on at the time of the transfer. On 7/5/24 the Administrator, Director of Nursing, Social Services Director and Activities Director, inspected 100% of the residents to ensure all residents had appropriate footwear for any potential transport, whether scheduled or not. Only one resident did not have appropriate shoes for their given shoe	

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with the MDS Coordinator revealed under Resident #79's annual MDS assessment the wording "not applicable" meant the resident was unable to ambulate with assistance during the assessment period.

A care plan initiated on 11/29/2022 and revised on 04/10/24 revealed a focus area related to Resident #79 being at risk for falls related to gait/balance problems and psychotropic medication use. The goal was for Resident #79's falls to be minimized with staff intervention through the next review date. Interventions included reminding the resident to use a wheelchair for mobility, ensuring the resident was wearing appropriate footwear while out of bed and to anticipate the needs of the resident.

On 02/25/25 at 1:00 PM an observation was conducted of the facility transportation bus. The transportation bus had a total of 2 seating rows on the passenger side, and 3 rows of seats on the driver's side. On the passenger side of the bus at the rear tire area was a large ramp that lowered down and was used to bring residents onto the bus using their wheelchairs. There were three steps leading onto the bus from the front entrance at the drivers steering wheel.

A nursing note dated 06/25/24 at 12:30 PM written by the Director of Nursing revealed Resident #79 left the facility at approximately 10:30 AM for an outing with other residents and three facility staff members via the facility transportation bus. Upon return at 12:10 PM, per staff statement, staff informed all residents not to unbuckle their seat belts or to rise until the staff went to assist the residents from their seats. Resident #79 was sitting in the second row of

size. The Director of Nursing purchased him a pair of lace up shoes for outings and medical appointments. Given there was only one resident, transportation was notified by the Director of Nursing not to transport him until the new shoes arrived. They were ordered and once edema was resolved and the facility could find size 20 shoes to accommodate his physical structure. No transports for this resident were impacted.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:

On 6/25/2024, the Director of Nursing will ensure adequate supervision is provided by determining the need of each resident being transported. This will be conveyed to the Van Driver to ensure compliance with the level of supervision required. This measure was initiated on 6/25/24.

All residents will be required to have appropriate footwear which, at the minimum, must have closed toes, a closed heel and non-skid soles. Slippers and other slide on footwear will be strictly prohibited in order to be transported by the facility van or approved vendor. Residents with confusion and poor safety awareness will require a staff person or trained volunteer to increase basic supervision during transport. Beginning on 6/26/24, the weekly transportation schedule will be reviewed in morning meeting prior to any transport and if a

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seats, per staff Resident #79 unbuckled her seatbelt and attempted to exit the facility bus without assistance while staff were preparing to assist residents to exit the bus. The resident was wearing fleece lined shoes. Resident #79 slid out of her shoe and tumbled down the steps landing on her right side in the parking lot. A STAT (immediate) response was called, and Resident #79 was immediately assessed by the facility Nurse Practitioner and nursing staff. A raised abrasive area was noted to the resident's right scalp, she complained of pain to her right shoulder. Resident #79 was taken to her room for a full body assessment noting multiple abrasive areas. During the time of the assessment Resident #79 complained of dizziness and nausea, vomiting four times with diarrhea noted during incontinent care. The Nurse Practitioner was notified and gave orders to send the resident to the Emergency Department for an evaluation. Resident #79's Responsible Party (RP) was notified of the resident's condition, incident and need to send to the Emergency Department. The RP stated the resident was impulsive and attempted to get up without assistance all of the time. Emergency Medical Services (EMS) arrived at the facility at approximately 12:50 PM to transport the resident to the hospital.

On 02/25/25 at 12:23 PM an interview was conducted with the Activities Director. During the interview she stated on 06/25/24 she had taken Resident #79 on an outing for ice cream via the transportation bus with two other staff members and a volunteer. Four residents were on the bus and she was familiar with each of the residents prior to going on the outing. Upon arrival back to the facility after Transportation Driver #1 had parked the bus and got off to go to the rear of the

resident needs increased supervision, the Director of Nursing will ensure it is available at the time. Increased supervision will be assigned by the Transportation Coordinator after notification by the Director of Nursing on 7/1/2024. Those individuals assigned for increase supervision , will be trained verbally by the Administrator or Director of Nursing prior to service and will include how to encourage the resident to remain seated and fastened until the van driver can safely help them off the transport vehicle. Those selected will have proper training on keeping residents safe. If utilizing a trained volunteer, the training will include how to encourage the resident to remain seated and fastened until facility staff can assist them off the transport. This training will be provided by the Administrator during volunteer orientation before their service begins. Volunteers will be instructed on identifying unsafe situations—such as when a resident might unbuckle a seatbelt while the van is in motion, or when a resident is at risk of falling out of their seat—and will be trained to take appropriate measures to minimize potential negative outcomes such as encouraging the resident to remain seated and refastening the buckle, and alerting the driver. However, at no point will volunteers be responsible for securing or transferring residents.

Starting on 6/30/2024, the Social Services Director or Director of Nursing will bring the transportation schedule to the morning meeting, Monday through Friday. The

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F 689	Continued From page 26 bus to open the ramp. She (the Activities Director) gathered the trash and exited via the front entrance along with the Volunteer. She stated when she exited the bus all residents were still buckled in their seats. The Activities Assistant was behind her getting off of the bus and stated to the residents to stay in their seats, they would be assisting them in a minute. The interview revealed Resident #79 was confused at times but she did not think the resident would get out of her seat to ambulate without assistance. The Activities Director stated she was in the sunroom of the facility directly in front of where the bus was parked throwing away the trash with the Volunteer. She stated after throwing away the trash she exited the sunroom and that was when she heard a loud thump and Resident #79 yelled out. She ran over to see Resident #79 on the asphalt at the bottom of the steps. The Activities Director then ran back in the facility and paged for assistance to the parking lot as the Activities Assistant and Transportation Driver #1 stayed with Resident #79. The Director of Nursing and Nurse Practitioner came and assessed Resident #79 along with other staff members. Resident #79's slipper was found on the top step of the bus. She stated when the incident happened nobody had seen Resident #79 get up and out of her seat on the bus. The Activities Director stated looking back on the incident a staff member should have stayed on the bus with the residents and not left them unattended. On 02/25/25 at 12:35 PM an interview was conducted with the Activities Assistant. During the interview she stated she, the Activities Director, Transportation Driver #1 and a Volunteer had taken Resident #79 on an outing to get ice cream on 06/25/24. There were four residents in total on	F 689	Director of Nursing and Social Service Director, having been informed of this responsibility on 6/25/2024, will ensure that any resident requiring increased supervision is properly identified and that necessary measures are in place. On 6/25/2024, the administrator informed the Staff Development Coordinator and Human Resources Specialist of the need to add training to orientation for all new hires regarding the need for residents to wear appropriate footwear. This will be covered as part of the general orientation for all departments. Training for increased supervision will only be given to those staff members assigned to transports for increased supervision. (That training is outlined in this plan.) On 6/25/24 all activity staff, facility transportation driver, and contracted vendor that provides outside non-emergency transportation when the facility transportation is not available were educated by the facility Administrator and Director of Nursing that each resident must be dressed appropriately for any outing which includes safe (closed toe, closed/strapped heel, non-slip) footwear. (The facility had only one driver at the time of the incident.) On 6/25/24 education was provided to all staff by nurse managers, department heads, and/or special assigned nurse on the need for each resident to be dressed appropriately for any outing which includes safe (closed toe, closed/strapped heel, non-slip) footwear. This in servicing	

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F 689	Continued From page 27 the outing and she was familiar with Resident #79 prior to the outing. Upon returning to the facility, Transportation Driver #1 opened the front door and got off of the bus. Next, the Activities Director and Volunteer exited the bus to throw trash away. She stated before exiting the bus herself she told the residents to remain seated, that her and Transportation Driver #1 would start unloading the residents from the back of the bus. All residents were buckled and secure when she exited the bus via the front entrance. She stated she did not think Resident #79 would unbuckle her seat belt and stand up without assistance. She stated when she walked down the steps, the front door was left open. She went to the back of the bus to lower the wheelchair lift to help Transportation Driver #1. All of the residents onboard required the use of the wheelchair ramp to exit. She stated shortly after she got to the rear of the bus Resident #79 had unbuckled herself, lost her footing and fell down the bus steps out of the front entrance. The Activities Assistant did not witness Resident #79 unbuckle her seat belt or stand up but assumed that was what happened by the sequence of events leading to the fall. The interview revealed it happened quickly after she exited the bus. The Activities Assistant stated she ran to her and immediately put her hands under the resident's head because it was a hot day and the asphalt was hot. The Activities Director ran into the building to get help. The Director of Nursing, nurses and Nurse Practitioner went to the resident to assess her injuries. The Nurse Practitioner stated to the staff she wanted to get the resident up off of the ground because of the hot pavement. The Activities Assistant stated she backed up from the situation at that time because she was not clinically trained, and she let the other staff handle the situation. The Activities	F 689	was to be completed by 7/2/24. This training may also be completed via phone after 7/3/24 if staff did not work during the stated period. No staff will be eligible to work until he/she has completed this education whether in person or by phone. The training for properly dressed residents including proper footwear was provided in person by the Staff Development Coordinator, Director of Nursing, or the Administrator. The facility employed no agency staff at the time of the event. On 6/25/24 the Van Driver was educated by the Director of Nursing that they were the ultimate “stop gate” to ensure everyone has safe footwear on prior to transfer. If a person does not have proper foot attire, they are to immediately notify the Director of Nursing or Administrator for further direction. To ensure on-going compliance, the van drivers will receive annual training on proper foot attire for all residents before the transportation is provided. This annual training will be completed by the administrator and maintenance director. This will occur during their annual evaluation when they are re-in serviced on all aspects of safe transport which includes, but not limited to, properly restraining wheelchairs, ensuring passengers are wearing seat belts, driving test, etc. This will be maintained in their employment file. If the facility hires a new driver, that driver will be trained by the Administrator on the need for all residents being transported to have appropriate footwear at the time they are training on operating the van,	

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F 689	Continued From page 28 Assistant stated no staff members were on the bus when Resident #79 stood up and ambulated to the front entrance and fell down the steps. She stated she could not see Resident #79 stand up from where she was positioned at the rear of the bus. The interview revealed she felt a staff member should have remained on the bus at the time of the incident with the residents. She stated she felt like she was very close to the residents being at the rear ramp but it was too far away to have seen Resident #79 unbuckle herself and get up. On 02/25/25 at 4:00 PM an interview was conducted with Transportation Driver #1. During the interview she stated on 06/25/24 she had taken Resident #79 on an outing with the Activities Director, Activities Assistant and a Volunteer. She stated when they returned to the facility, she parked the transportation bus and put the vehicle's breaks on. She left the bus running to keep the residents cool because it was a hot day. Transportation Driver #1 stated she exited through the front entrance first, and when she exited there were two staff members (the Activities Director and Activities Assistant) and the Volunteer still on the bus. The interview revealed the residents, including Resident #79, were placed onto the transportation bus via a rear wheelchair ramp. The residents were wheeled onto the ramp in their wheelchairs and placed in the row seating by the staff members. The wheelchairs were stored at the rear of the bus during transport. She stated she was at the rear of the bus opening the door when she heard Resident #79 screaming. When she looked, Resident #79 was lying on the asphalt outside the front of the bus. She stated she did not know where the other staff members were at the time	F 689	including but not limited to, driving, lift operation, properly securing residents and all safety measures. On 6/26/24 a letter was initiated by the facility Administrator to families notifying them of the facility's new requirement on safe (closed toe, closed/strapped heel, non-slip) footwear for residents to be transported. These letters were mailed on 7/1/24 by the facility administrative assistant. The need for proper footwear is shared on admission with all new admissions or their representatives that could potentially need transportation. This is conveyed by the Admissions Director and who was instructed to do so by 6/26/2024 when the Administrator begins the process to notify families of existing residents. Residents were also informed with the same letter and through Resident Council on 07/01/24 by the Director of Nursing. On 7/1/24, the Resident Council was informed by the Director of Nursing of the need for all residents being transported to have safe footwear that includes, closed toe, closed/strapped heel, non-slips such as tennis shoes, etc. Slippers or shoes without a back covering the heel or heel strap are strictly prohibited. 4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur: "Angel Rounds" are conducted on all residents by assigned managers to specific rooms to ensure all rooms are inspected and the resident/resident	

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of the fall but she did remember one of the Activities staff members was the first to get to Resident #79. The interview revealed she assumed Resident #79 had fallen from the three steps located at the front entrance of the bus but she did not witness the resident fall.
Transportation Driver #1 stated she never left a resident unattended on the bus and the only reason she got off and left the residents was because other staff members were on board. She stated she did not know at the time that everyone had exited the bus and left the residents unattended. The interview revealed someone should have remained with the residents and all staff members should not have exited the bus.

On 02/25/25 at 12:08 PM an interview was conducted with Wound Nurse #1. Wound Nurse #1 stated on 06/25/24 she was notified by a staff member (name she could not recall) that Resident #79 had fallen out of the transportation bus, and she needed to go outside to the parking lot. She stated when she got to the bus Resident #79 was lying on the pavement with her feet toward the bus at an angle on her right side. The Nurse Practitioner assessed Resident #79 and said it was okay for staff to transfer her into a wheelchair because she was concerned about the ground being hot. She stated the staff rolled Resident #79 onto a sheet then sat her up using a gait belt to get her into the wheelchair. Resident #79 was responsive and alert but never oriented. Wound Nurse #1 stated Resident #79 was confused at baseline and there seemed to be no change in her cognition at the time of the incident. Wound Nurse #1 stated Resident #79 did not say she was in pain when they transported her to her room and got her into bed. The resident began vomiting once she was in bed and she notified

belongings in each room at a minimum of three times a week. On 7/1/2024, the Administrator instructed those managers responsible for “angel rounds” to include assessing footwear for proper shoes as described to proactively address any footwear issues prior to any need for transportation. During this meeting on 07/01/24, the Director of Nursing described Resident #79’s slippers and the concerns developed because of the facility’s investigation. The comparison was made of slippers and tennis shoes. Furthermore, they were instructed that any concerns observed should be immediately reported to the Director of Nursing or Administrator and documented on their rounding forms. These rounding sheets, which are completed three times a week by managers assigned to specific rooms by the Administrator, cover various compliance areas.
It was determined on 6/25/2024, the need to ensure every resident had proper footwear prior to transportation. Beginning 6/25/2024, the Director of Nursing will inspect 100% of all residents being transported for one week and then randomly select 4 residents for 2 weeks from the transport schedule prior to departure. Random, unannounced prn audits will ensure on on-going compliance. The results of these audits will be reported to the facility IDT during the daily morning meeting Monday through Friday for 2 weeks then weekly for 2 weeks then monthly for 2 months and then randomly, unannounced to ensure compliance with this plan. On

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F 689	Continued From page 30 the DON who said to send the resident to the hospital for an evaluation. An undated/untimed evaluation written by Wound Nurse #1 following the incident on 06/25/24 revealed Resident #79 had the following injuries : right inner back bruise, two skin tears on the right elbow, three closed raised areas on the right hand, right shoulder burn open, right shoulder bone dislocated, left hand two open skin tears, complaints of right ankle pain, quarter size abrasion to the right knee, left great toe abrasion, left second toe abrasion, left top of foot skin tear, complaints of back pain, right forehead raised abrasion, left forehead raised abrasion, Resident #79 could not turn her head all of the way to the right side, right tongue hematoma, right front tooth cracked and right side of head goose egg. Resident #79 had stated during the assessment that nobody told her not to move and she did not know where she was going. She did not remember falling and did not have a headache. Resident #79's vital signs were blood pressure 143/77 (normal range 120/80), pulse 80 (normal range 60-90), respirations 16 (normal range 12-20) and oxygen saturation level 90% (normal range 90% or greater). On 02/25/25 at 11:46 AM an interview was conducted with the Director of Nursing (DON). During the interview she stated, based on her investigation on 06/25/24, three staff members (Activities Director, Activities Assistant and Transportation Driver #1) had taken Resident #79 on an outing to get ice cream along with three other residents. When they returned from the outing and parked the transportation bus, Transportation Driver #1 got off of the bus. The Activities Director and a Volunteer that was on the	F 689	6/27/2024 the Interdisciplinary Team met and decided to monitor the plan implemented and take to the QAPI meeting until 01/01/25 or longer if deemed necessary. The monitoring for increased supervision began on 7/1/2024 by the Director of Nursing and included reviewing the scheduled transports for the week in advance to ensure increased supervision is provided for any identified residents. If increases supervision is needed, the Director of Nursing or Administrator will ensure the increased supervision is provided. All identified transports will be monitored for 8 weeks and then as needed to ensure on-going compliance. The results of these audits will be monitored by the QA committee until 1/1/2025. Compliance Established on 07/03/24 On 2/26/25 Resident #138 was transferred safely to the bed without incident. On 3/5/25 an audit of all residents requiring a total lift conducted by the Director of Nursing (DON), nurse Unit Managers (UM), Staff Development Coordinator, and the Infection Preventionist nurse (IPN) to ensure any resident requiring a total lift was noted in the care guide (a method of communicating the lift requirement to any CNA caring for these residents).	

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F 689	Continued From page 31 bus got off to throw away trash. The Activities Assistant got off of the bus to assist Transportation Driver #1 and told the residents to stay seated prior to getting off. The DON stated based on the sequence of events the facility had put together, that Resident #79 unbuckled herself and attempted to ambulate without assistance getting to the first step of the bus. When she reached the first step, she was wearing "slippers" that came off and she then fell down the steps out onto the pavement of the parking lot. The Activities Assistant and Transportation Driver #1 stayed with Resident #79 while the Activities Director ran inside of the building to get help. The Nurse Practitioner was in the building that day and went out to the parking lot to assess the resident and obtain vital signs. Resident #79 had multiple abrasions that were visible. Resident #79 had a knot on the back of her head, but no open areas. The DON stated the staff used a gait belt and Resident #79 was able to stand up with staff assist to get into the wheelchair. Resident #79 was then taken to her room and assisted to the bed via a gait belt and staff assistance. The Wound Nurse assessed the resident, and the DON went to obtain a vital sign machine. The Wound Nurse called the DON on the phone and stated Resident #79 was vomiting a lot, and she (the DON) stated to them to send the resident to the hospital for an evaluation. The DON stated Resident #79 seemed alert after the incident however wasn't as, "feisty" as she normally acted. She stated Resident #79 was unstable and unable to ambulate without assistance from staff at her baseline and had poor safety awareness. EMS arrived to the facility and transported the resident to the hospital for an evaluation. Nurse Practitioner note dated 06/25/24 revealed	F 689	On 3/16/2025 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), Infection Preventionist nurse (IPN), and special assigned nurse began education to all nursing staff on the need to have 2 persons present when transferring a resident with a total lift. Beginning 3/16/25 Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), Infection Preventionist nurse (IPN), and special assigned nurse will randomly monitor 6 residents for 4 weeks, then 3 residents 4 weeks for 4 weeks to ensure compliance with this plan of correction. The facility has contracted with a lift expert who will ensure proper lift utilization, education and monitoring. Her monitor may also be used towards the number of monitors per week as described here. Beginning the month of April 2025 and continuing for 3 months, the DON will report the findings of the monitoring to members quality assurance (QA) committee meeting. The QA Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance.	

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staff reported Resident #79 with a fall getting off of the transportation bus. On arrival to the resident she was noted laying on the ground outside. Resident #79 was noted to be alert at baseline and stated she was having right shoulder pain. The resident was examined while lying on the ground. She was noted to have a small lump/hematoma to her scalp, abrasion noted to her left shoulder with mild deformity. No spine tenderness was reported. Staff were cleared to assist the resident to her wheelchair due to elevated temperature and hot grounding to decrease the risk of a burn. A mild deformity was noted to the right shoulder with mild crepitus (crackling, popping, or grinding sound) as well, however Resident #79 was noted to have a history of an old fracture reported to the arm with chronic mild deformity. Initial plans were to obtain x-rays of left arm/shoulder/chest and initiate neurological checks but once the resident returned to her room and was repositioned, staff reported 2-3 episodes of vomiting. Therefore, orders were given to send the resident to the hospital for an evaluation. Resident #79 was noted with chronic/progressive dementia. She was documented as being alert and able to make needs known however was forgetful with a short term memory.

On 02/25/25 at 12:41 PM an interview was conducted with the Nurse Practitioner (NP). During the interview she stated she received a call that Resident #79 had experienced a fall from the transportation bus in the parking lot. The NP immediately went outside to see Resident #79 lying on the ground and noticed her shoes were on the steps of the bus. She stated she did a quick assessment and observed no spine tenderness or obvious deformities. She stated

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Resident #79 was stable enough to move her from the ground because it was hot that day and she worried the resident would get burned from the asphalt. The staff obtained vital signs and got the resident up in a wheelchair. She stated she asked baseline questions and Resident #79 complained of a little arm pain, so she ordered a radiology exam based on her complaints and physical assessment. She told the staff to start neurological assessments and monitor Resident #79 during the first hour, however, after she was transported to her room she began vomiting and was sent to the hospital. The NP stated she did not go to the resident's room to reassess her she just gave the orders to send her out. The NP stated Resident #79 had returned to baseline since the incident.

An Emergency Department (ED) report dated 06/25/24 at 2:17 PM revealed Resident #79 had experienced a fall coming off of a bus. She was noted to hit her head and right shoulder during the fall and had a hematoma to the right side of her head. Resident #79 did not remember the event and stated she was experiencing pain in her right shoulder, pointing to the back of her shoulder. Neurosurgery, trauma service and orthopedic surgery were consulted.

A hospital discharge summary dated 07/05/24 revealed Resident #79 was evaluated for a mechanical fall resulting in a left temporal subarachnoid hemorrhage, right clavicle fracture, right humeral fracture and bilateral rib fractures. Resident #79 was admitted into the hospital on 06/25/24 where she received services from the neurology team along with the trauma surgery team. Resident #79 was found to be stable with orders to remain non-weight bearing to the right

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upper extremity. She was treated for aspiration pneumonia with intravenous antibiotics during the hospital stay and discharged back to the facility on 07/05/24.

On 02/25/25 at 4:30 PM a follow up interview was conducted with the Nurse Practitioner. The NP stated while in the hospital Resident #79 was also treated for aspiration pneumonia. The NP stated the aspiration pneumonia could have possibly come from the resident vomiting however there would be no way of definitively knowing. She stated the facility staff would not have been able to tell the resident aspirated immediately, symptoms would have been seen later into her hospitalization.

On 02/25/25 at 2:40 PM an interview was conducted with the Medical Director (MD). During the interview he stated the Nurse Practitioner was in the building at the time of the incident and assessed Resident #79. The resident had a diagnosis of dementia with episodes of confusion. She attempted to ambulate without assistance from staff and had a fall from the facility transportation bus.

On 02/27/25 at 5:00 PM an interview was conducted with the Administrator. The Administrator stated that he felt it was an "imperfect" day. He stated he would not change anything about the day or how his staff reacted because it was an unavoidable fall. The Administrator stated the facility had no indication Resident #79 was going to unbuckle herself and attempt to ambulate off of the transportation bus.

The Administrator was notified of the immediate jeopardy on 02/25/25 at 5:05 PM.

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The facility provided the following immediate jeopardy removal plan:

1. Address how corrective actions will be accomplished for those residents who have been affected by the deficient practice:

On 06/25/24 the facility van returned to the facility following an outing with 4 residents, 3 staff and a volunteer. When the van returned to the facility, the Activities Director and volunteer exited the van to discard the waste. The Van Driver who is the only one trained to operate the lift exited the van to begin the unloading process in the lift area. The Activities Assistant remained in the van and instructed residents to remain seated and they would be unloaded starting at the back. The Activities Assistant then exited the van to assist the Van Driver who had opened the door. No staff were in the van, but the Van Driver and Activities Assistant were at the lift and within 60 inches of the resident. Resident #79 was seated closest to the staff, unbuckled herself, ambulated to the steps of the van and fell to the asphalt after being reminded by staff to stay seated. There were no staff members in the van at the time of the event, but staff were in speaking distance at the rear of the van. After being assessed, one of the resident's slippers were noted on the top step and the other was lower on the steps indicating she stepped on the back of her slipper which caused the fall.

On 6/25/24, the affected resident, Resident # 79, was immediately assessed by the onsite nurse practitioner prior to her being moved. Upon the initial assessment, it was deemed the resident was safe to be transported into the facility where

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she was placed in bed and continued to be assessed. Emergency Medical Services (EMS) was notified to transport the resident to the hospital for additional tests and exams. On 7-5-2024, Resident #79 was readmitted to the facility.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice:

On 06/25/24 during her initial interview with the Van Driver, the Director of Nursing inquired if any other resident had fallen or had any other "near miss" on the van. No other residents were identified.
On 6/26/24 the Interdisciplinary Team consisting of all department managers, Administrator and Director of Nursing met to review residents with outside appointments. They met to identify residents scheduled for transport through 7/6/24 using the medical record to identify residents that were unable to make their needs known, appropriately respond to direction, had a BIMS score less than 10, and those unable to comply with standard safety precautions. Identified residents will have increased supervision on their transport to and from the facility as well as proper footwear. Moving forward, the facility will conduct weekly reviews of all residents scheduled for transportation to ensure ongoing compliance with this protocol.

In addition, residents must have safe and appropriate footwear on at the time of the transfer. On 7/3/24 the Administrator, Director of Nursing, Social Services Director and Activities Director, inspected 100% of the residents to ensure all residents had appropriate footwear for

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any potential transport, whether scheduled or not. Only one resident did not have appropriate shoes for their given shoe size. The Director of Nursing purchased him a pair of lace up shoes for outings and medical appointments. Given there was only one resident, transportation was notified by the Director of Nursing not to transport him until the new shoes arrived. They were ordered once edema was resolved and the facility could find size 20 shoes to accommodate his physical structure. No transports for this resident were impacted.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:

On 6/25/2024, the Director of Nursing will ensure adequate supervision is provided by determining the need of each resident being transported. This will be conveyed to the Van Driver to ensure compliance with the level of supervision required. This measure was initiated on 6/25/24.

All residents will be required to have appropriate footwear which, at the minimum, must have closed toes, a closed heel and non-skid soles. Slippers and other slide on footwear will be strictly prohibited in order to be transported by the facility van or approved vendor. Residents with confusion and poor safety awareness will require a staff person or trained volunteer to increase basic supervision during transport. Beginning on 6/26/24, the weekly transportation schedule will be reviewed in morning meeting prior to any transport and if a resident needs increased supervision, the Director of Nursing will ensure it is available at the time. Increased supervision will be assigned by the Transportation Coordinator

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after notification by the Director of Nursing on 7/1/2024. Those individuals assigned for increase supervision , will be trained verbally by the Administrator or Director of Nursing prior to service and will include how to encourage the resident to remain seated and fastened until the van driver can safely help them off the transport vehicle. Those selected will have proper training on keeping residents safe. If utilizing a trained volunteer, the training will include how to encourage the resident to remain seated and fastened until facility staff can assist them off the transport. This training will be provided by the Administrator during volunteer orientation before their service begins. Volunteers will be instructed on identifying unsafe situations-such as when a resident might unbuckle a seatbelt while the van is in motion, or when a resident is at risk of falling out of their seat-and will be trained to take appropriate measures to minimize potential negative outcomes such as encouraging the resident to remain seated and refastening the buckle, and alerting the driver. However, at no point will volunteers be responsible for securing or transferring residents.

Starting on 6/30/2024, the Social Services Director or Director of Nursing will bring the transportation schedule to the morning meeting, Monday through Friday. The Director of Nursing and Social Service Director, having been informed of this responsibility on 6/25/2024, will ensure that any resident requiring increased supervision is properly identified and that necessary measures are in place.

On 6/25/2024, the Administrator informed the Staff Development Coordinator and Human Resources Specialist of the need to add training

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to orientation for all new hires regarding the need for residents to wear appropriate footwear. This will be covered as part of the general orientation for all departments. Training for increased supervision will only be given to those staff members assigned to transports for increased supervision. (That training is outlined in this plan.)

On 6/25/24 all activity staff, facility transportation driver, and contracted vendor that provides outside non-emergency transportation when the facility transportation is not available were educated by the facility Administrator and Director of Nursing that each resident must be dressed appropriately for any outing which includes safe (closed toe, closed/strapped heel, non-slip) footwear. (The facility had only one driver at the time of the incident.)

On 6/25/24 education was provided to all staff by nurse managers, department heads, and/or special assigned nurse on the need for each resident to be dressed appropriately for any outing which includes safe (closed toe, closed/strapped heel, non-slip) footwear. This in servicing was to be completed by 7/2/24. This training may also be completed via phone after 7/3/24 if staff did not work during the stated period. No staff will be eligible to work until he/she has completed this education whether in person or by phone. The training for properly dressed residents including proper footwear was provided in person by the Staff Development Coordinator, Director of Nursing, or the Administrator. The facility employed no agency staff at the time of the event.

On 6/25/24 the Van Driver was educated by the

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Director of Nursing that they were the ultimate "stop gate" to ensure everyone has safe footwear on prior to transfer. If a person does not have proper foot attire, they are to immediately notify the Director of Nursing or Administrator for further direction. To ensure on-going compliance, the van drivers will receive annual training on proper foot attire for all residents before the transportation is provided. This annual training will be completed by the Administrator and Maintenance Director. This will occur during their annual evaluation when they are re-in serviced on all aspects of safe transport which includes, but is not limited to, properly restraining wheelchairs, ensuring passengers are wearing seat belts, driving test, etc. This will be maintained in their employment file. If the facility hires a new driver, that driver will be trained by the Administrator on the need for all residents being transported to have appropriate footwear at the time they are training on operating the van, including but not limited to, driving, lift operation, properly securing residents and all safety measures.

On 6/26/24 a letter was initiated by the facility Administrator to families notifying them of the facility's new requirement on safe (closed toe, closed/strapped heel, non-slip) footwear for residents to be transported. These letters were mailed on 7/1/24 by the facility Administrative Assistant. The need for proper footwear is shared on admission with all new admissions or their representatives that could potentially need transportation. This is conveyed by the Admissions Director and who was instructed to do so by 6/26/2024 when the Administrator begins the process to notify families of existing residents. Residents were also informed with the same letter and through Resident Council on

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07/01/24 by the Director of Nursing.

On 7/1/24, the Resident Council was informed by the Director of Nursing of the need for all residents being transported to have safe footwear that includes, closed toe, closed/strapped heel, non-slips such as tennis shoes, etc. Slippers or shoes without a back covering the heel or heel strap are strictly prohibited.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur:

"Angel Rounds" are conducted on all residents by assigned managers to specific rooms to ensure all rooms are inspected and the resident/resident belongings in each room at a minimum of three times a week. On 7/1/2024, the Administrator instructed those managers responsible for "angel rounds" to include assessing footwear for proper shoes as described to proactively address any footwear issues prior to any need for transportation. During this meeting on 7/1/2024, the Director of Nursing described Resident #79's slippers and the concerns developed because of the facility's investigation. The comparison was made of slippers and tennis shoes. Furthermore, they were instructed that any concerns observed should be immediately reported to the Director of Nursing or Administrator and documented on their rounding forms. These rounding sheets, which are completed three times a week by managers assigned to specific rooms by the Administrator, cover various compliance areas.

It was determined on 6/25/2024, the need to ensure every resident had proper footwear prior to transportation. Beginning 6/25/2024, the

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Director of Nursing will inspect 100% of all residents being transported for one week and then randomly select 4 residents for 2 weeks from the transport schedule prior to departure. Random, unannounced prn audits will ensure on on-going compliance. The results of these audits will be reported to the facility interdisciplinary team during the daily morning meeting Monday through Friday for 2 weeks then weekly for 2 weeks then monthly for 2 months and then randomly, unannounced to ensure compliance with this plan. On 6/27/2024 the Interdisciplinary Team met and decided to monitor the plan implemented and take to the QAPI meeting until 1/1/2025 or longer if deemed necessary.

The monitoring for increased supervision began on 7/1/2024 by the Director of Nursing and included reviewing the scheduled transports for the week in advance to ensure increased supervision is provided for any identified residents. If increased supervision is needed, the Director of Nursing or Administrator will ensure the increased supervision is provided. All identified transports will be monitored for 8 weeks and then as needed to ensure on-going compliance. The results of these audits will be monitored by the Quality Assurance committee until 1/1/2025.

Alleged date of immediate jeopardy removal: 07/03/24

On 02/27/25, the immediate jeopardy removal plan was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff, department heads and transportation drivers had received training on the need for each resident to be dressed

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appropriately for any outing which includes safe (closed toe, closed/strapped heel, non-slip) footwear and remaining with residents while on the transportation bus. Transportation Driver #1 confirmed she was educated by the Director of Nursing that she must ensure residents had safe footwear prior to transfer and to never leave a resident unattended while on the transportation bus. The facility's in-service log, monitoring results and training material was reviewed. The facility's immediate jeopardy removal date of 07/03/24 was validated on 02/27/25.
This example is not past non compliance due to example 2 for f689.
2. Resident #138 was admitted to the facility on 10/09/24 with diagnoses which included hypertension, muscle weakness and Alzheimer's disease.

Review of Resident #138's most recent significant change Minimum Data Set (MDS) assessment revealed the resident was severely cognitively impaired and was dependent on staff for all activities of daily living (ADL).

Review of Resident #138's Care Area Assessment summary dated 01/14/25 revealed she was at risk for falls related to unsteady gait and muscle weakness. Staff will provide transfers as needed. The resident is at risk of a decline in activities of daily living (ADL) related to acute illness and muscle weakness. Nursing staff will provide assistance with ADL as needed. The resident is at risk of altered communication related to cognitive impairment. Staff will anticipate needs and provide assistance as needed. Staff will continue to monitor and anticipate needs in effort to prevent further declines and treat/manage current conditions.

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Review of Resident #138's care plan dated 01/14/25 revealed a focus area for ADL/mobility related to requiring assistance related to impaired mobility. The goal was for the resident to improve current level of function in ADL. The interventions included in part: Total lift for transfers with 2 staff.

A continuous observation on 02/26/25 from 4:38 PM until 4:43 PM revealed Resident #138 screaming out and when walked in the room, Nurse Aide (NA) #2 was lifting Resident #138 to bed in a mechanical lift without the assistance of a second staff member. NA #2 was operating the lift mechanism and there was no one holding onto the resident in the lift pad and directing her onto the bed. Resident #138 was placed in bed with the lift pad and continued to scream until she was adjusted in the bed by NA #2

An interview on 02/26/25 at 4:44 PM with NA #2 revealed she had gotten Resident #138 up with the mechanical lift by herself because she stated the resident was sliding out of her wheelchair and she didn't want her to fall. NA #2 stated she had yelled for help but didn't feel like she could wait so she went ahead and got her up in the lift by herself. NA #2 further stated she had had education on mechanical lifts and knew she was not supposed to get a resident up in the mechanical lift without a second staff member to assist. She indicated she had been provided with education on new equipment and lifts and other equipment throughout the year.

A telephone interview on 02/26/25 at 8:19 PM with NA #1 who was working with NA #2 on the hall revealed NA #1 had not asked her to assist her with getting Resident #138 up with the

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F 689	Continued From page 45 mechanical lift. NA #1 stated she had been available to assist with getting Resident #138 up with the mechanical lift but had not been asked by NA #2 for assistance. A telephone interview on 02/26/25 at 8:29 PM with Nurse #1 who was assigned to care for Resident #138 from 7:00 AM to 7:00 PM revealed she had not been asked to assist NA #2 in getting Resident #138 up in the mechanical lift. Nurse #1 stated she was a new nurse and had only been working for 3 weeks and was not familiar with the facility's protocols for mechanical lifts. She further stated she was not sure if mechanical lifts required 2 staff members when transferring residents. An interview on 02/27/25 at 3:57 PM with the Director of Nursing (DON) revealed mechanical lifts required 2 staff members when transferring residents. She stated NA #2 should have gotten assistance prior to getting Resident #138 up in the mechanical lift and transferring her to bed. An interview on 02/27/25 at 4:31 PM with the Administrator revealed he felt NA #2 did the best she could have given the resident was sliding from her wheelchair. He stated although NA #2 did not follow the facility's policy for mechanical lifts he thought it was admirable that she prevented Resident #138 from falling.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		3/25/25

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F 690	Continued From page 46 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility failed to secure a urinary catheter tubing to prevent tension and/or trauma for 1 of 3 residents (Resident #26) reviewed for urinary catheters. The findings included:	F 690	On 2/26/25, Nurse #2 applied a securing device on resident #26 right leg to ensure resident #26 indwelling urinary catheter tubing was not pulled taut. (On 3/5/25 resident #26's indwelling urinary catheter was discontinued as per orders by the urologist. Resident #26 continues to void	

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F 690	Continued From page 47 Resident #26 was admitted to the facility on 5/30/2022 with diagnoses which included obstructive uropathy (condition where urine flow is blocked). A physician's order dated 2/4/2025 revealed Resident #26 was ordered to have a urinary catheter with a diagnosis of obstructive uropathy. Resident #26 was ordered to have the placement of his privacy bag and leg strap checked every shift. A quarterly Minimum Data Set (MDS) dated 2/7/2025 revealed Resident #26 was cognitively intact and had a urinary catheter. A care plan for Resident #26 dated 2/22/2025 did not contain a focus, goal, or interventions related to urinary catheters. The February 2025 Treatment Administration Record (TAR) revealed Resident #26 was documented as having the placement of his privacy bag and leg strap checked during the day on 2/24/2025 and 2/25/2025 by Nurse #1. An observation and interview were conducted on 2/24/2025 at 11:35 am. Resident #26 was observed lying in bed on his left side. Resident #26 had a catheter with a leg bag attached to his right leg with the top strap of the leg bag on top of his right knee and the bottom strap below his right knee. Resident #26 did not have a securement or stabilizing device and the catheter tubing was pulled taut. Resident #26 stated it was uncomfortable. An observation was conducted on 2/25/2025 at	F 690	without difficulty requiring no indwelling catheter.) On 3/5/25 an audit of all residents requiring an indwelling urinary catheter was conducted by the Director of Nursing (DON), nurse Unit Managers (UM), Staff Development Coordinator, and the Infection Preventionist nurse (IPN) to ensure any resident requiring an indwelling urinary catheter had the required securement or stabilizing device in place to prevent tension and or trauma. Any resident noted without a securement or stabilizing device was immediately corrected. On 3/16/2025 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), Infection Preventionist nurse (IPN), and special assigned nurse began education to facility/agency nursing staff on care of indwelling urinary catheters to ensure the resident has a securement device in place and tubing is secure to prevent taut. This education will be completed on 03/25/2025. On 3/16/25 the SDC added this education to the new hire packet and agency/contract nursing staff. After 3/26/2025, no nursing staff will be allowed to work until this education is completed. Beginning 3/16/25 Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), Infection Preventionist nurse (IPN), and special assigned nurse will begin monitoring to ensure any resident	

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F 690	Continued From page 48 3:07 pm. Resident #26 was observed lying in bed on his right side. Resident #26 had a catheter with a leg bag attached to his right leg with the top strap of the leg bag on top of his right knee and the bottom strap below his right knee. Resident #26 did not have a securement or stabilizing device and the catheter tubing was pulled taut. An interview was conducted on 2/26/2025 at 2:55 pm with Nurse #1. Nurse #1 stated Resident #26 had a urinary catheter due to urinary retention. Nurse #1 stated the nurses were responsible for checking the residents for a catheter securement device daily. Nurse #1 stated he had not noticed if Resident #26 had a securement device on 2/24/2025 or 2/25/2025. Nurse #1 stated he noticed Resident #26 did not have one on this morning (2/26/2025) and assumed it had fallen off. Nurse #1 stated he placed a securement device on Resident #26 this morning. An interview was conducted on 3/5/2025 at 8:51 am with the Director of Nursing (DON). The DON stated nurses were responsible for checking the placement of urinary catheter securement devices daily. The DON stated she was not aware Resident #26 did not have a securement device in place on 2/24/2025 or 2/25/2025. The DON stated she thought Resident #26 would remove the securement device on occasion.	F 690	requiring an indwelling urinary catheter has the required securement or stabilizing device in place to prevent tension and/or trauma. Any resident noted without a securement or stabilizing device will be corrected immediately and additional education provided to the nurse staff as indicated by the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), Infection Preventionist nurse (IPN), and special assigned nurse. This monitoring will continue on 6 random residents 5x/week for 4 weeks, then 3x/week for 4 weeks, then 2x/week for 4 weeks to ensure compliance with this plan of correction. Beginning the month of April 2025 and continuing for 3 months, the DON will report the findings of the monitoring to members quality assurance (QA) committee meeting. The QA Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697		3/25/25

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F 697	Continued From page 49 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, Resident, Medical Director, and Wound Care Physician interviews, the facility failed to ensure a resident with an unstageable pressure ulcer that required wound debridement (removal of dead tissue) had her pain controlled prior to attempted weekly wound debridement for 8 weeks and the facility failed to address a resident's pain after she had experienced pain with wound dressing changes for 1 of 3 residents (Resident #59) reviewed for pain management. On 12/11/24, 12/18/24, 01/01/25, 01/08/25, 01/15/25, 01/22/25, 01/29/25, 02/05/25, and 02/12/25 the Wound Care Physician attempted manual debridement but had to stop due to pain and on 02/26/25 during wound care treatment Resident #59 was observed crying, grimacing, and had verbal reports to stop the dressing change. The dressing change had been attempted within 21 minutes of Resident #59 receiving her first dose of pain medication. The findings included: Resident #59 was admitted to the facility on 10/31/2019 with diagnoses which included diabetes and Parkinsonism. A significant change Minimum Data Set (MDS) dated 12/19/24 revealed Resident #59 was severely cognitively impaired with no behaviors or rejection of care. Resident #59 require moderate assistance with toileting, bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated that Resident #59 had not	F 697	Review of Resident #59 pain assessment score for 30 days prior to survey entrance (2/24/25-3/4/25) indicated a pain score of “0”. This was conducted by the Director of Nursing. The Wound Care Physician documented Resident #59 required manual debridement which was aborted and changed to non-contact, non-thermal, low frequency ultrasound. Wound care dressing changes were stopped during surveyor observation as resident requested even after pain medications were given and resident requested for dressing change to stop. Wound care nurse then requested facility nurse practitioner (NP) to assess for additional pain management. Upon entry of NP to Resident #59’s room, Resident #59 was noting sleeping without note of pain, an additional order was added to Resident #59’s orders by the NP at that time in order of better pain management during wound dressing changes. On 3/5/25 a 100% audit was completed by the Director of Nursing (DON), Nursing Unit Managers (UM), Staff Development Coordinator (SDC), and the Infections Preventionist Nurse (IPN) ensuring each resident has adequate pain management in place and/or non-pharmacological pain management is in place and given timely prior to wound care in order for resident to manage his/her pain during wound care treatments. Any resident with	

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F 697	Continued From page 50 received scheduled pain medication, had not received any as needed pain medication, and received no nonpharmacological interventions for pain during the assessment reference period. Resident # 59 had no signs or symptoms of pain reported on the staff assessment of pain during the assessment reference period. Resident #59 was noted to have 1 unstageable pressure ulcer and was not coded as receiving hospices services. A care plan last updated on 12/26/24 read in part, Resident #59 was at risk for pain due to decreased mobility. The interventions were all add to the care plan on 03/11/23 and included: administer medications as ordered, anticipate the residents need for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of pain interventions, identify and record previous pain history and management of that pain and impact on function, monitor pain level every shift, monitor/document probably cause of each pain episode, monitor/document side effects of pain medication, and monitor/report to Nurse any signs or symptoms of nonverbal pain. The December 2024 physician's orders and Medication Administration Record (MAR) revealed Resident #59 had no medication ordered for pain. A wound care provider note dated 12/11/2024 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 50% thick adherent devitalized necrotic (dead) tissue present and 50% viable subcutaneous tissue present. Debridement was attempted but aborted due to pain.	F 697	reported/noted pain during wound care treatment was corrected through pain management medication/intervention via present order or licensed provider new order to ensure resident has acceptable pain management medication/intervention during wound care treatment. On 3/16/2025, the Director of Nursing (DON), Nursing Unit Managers (UM), Staff Development Coordinator (SDC), and the Infections Preventionist Nurse (IPN) audited and discussed each resident with wounds to ensure they have proper pain management, if necessary, prior to wound treatment. All nurses will be educated by 03/25/2025 on the expectation of ensuring those with pain associated with wound treatments are properly medicated prior to the treatment. On 3/16/25 the SDC added this education to the new hire packet and agency/contract nurse and medication aide packet. After 3/26/2025, no contracted agency/facility nursing staff will be allowed to work until education is completed to ensure each resident has adequate pain management in place and/or non-pharmacological pain management is in place & given timely prior to wound care in order for resident to manage an acceptable pain level during his/her wound care treatments as per state & federal guidelines and facility protocol. Beginning 3/16/25 The Director of Nursing (DON), Nursing Unit Managers (UM), Staff Development Coordinator (SDC), the	

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F 697	Continued From page 51 A wound care provider note dated 12/18/2024 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 10% thick adherent devitalized necrotic tissue present and 90% granulation tissue present. Debridement was attempted but aborted due to pain. The January 2025 MAR revealed Resident #59 had no medication ordered for pain. A wound care provider note dated 1/1/2025 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 10% slough, 80% granulation tissue, and 10% fascia present. Debridement was attempted but aborted due to pain. A wound care provider note dated 1/8/2025 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 20% slough and 80% granulation tissue present. Debridement was attempted but aborted due to pain. A wound care provider note dated 1/15/2025 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 10% slough and 90% granulation tissue present. Debridement was attempted but aborted due to pain. A wound care provider note dated 1/22/2025 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 10% slough and 90% granulation tissue present. Debridement was attempted but aborted due to pain.	F 697	Infections Preventionist Nurse (IPN), and/or the special assigned project nurse will monitor 6 residents weekly for 12 weeks to ensure each resident has adequate pain management in place and/or non-pharmacological pain management is in place & given timely prior to wound care in order for resident to manage an acceptable pain level during his/her wound care treatments as per state & federal guidelines and facility protocol. Beginning the month of April 2025 and continuing for 3 months, the DON will report the findings of the monitoring to the members of the Quality Assurance (QA) Committee meeting. The QA Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained.	

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A wound care provider note dated 1/29/2025 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 20% slough and 80% granulation tissue present. Debridement was attempted but aborted due to pain.

A wound care provider note dated 2/5/2025 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 10% slough and 90% granulation tissue present. Debridement was attempted but aborted due to pain.

A wound care provider note dated 2/12/2025 revealed Resident #59's was assessed and had a coccyx wound. A moderate amount of serous drainage with 10% slough, 80% granulation tissue and 10% subcutaneous tissue present. Debridement was attempted but aborted due to pain.

A physician's order dated 2/25/2025 revealed Resident #59 was ordered to receive tramadol (pain medication) 50 milligrams (mg) every 8 hours as needed for pain.

A physician's order dated 02/26/25 revealed Resident #59 was ordered Hydrocodone-Acetaminophen (opioid pain medication) 5/325 mg by mouth daily as needed for pain for 7 days. Administer prior to wound care change.

The February 2025 MAR revealed Resident #59 was documented as having a pain level of 5 out of 10 on 2/26/2025 during the day by Nurse #2 and at 11:30 AM received a dose of Tramadol 50

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mg by mouth.

A wound care observation was conducted on 2/26/2025 at 11:51 am with Wound Care Nurse #1 and Wound Care Nurse #2. When Resident #59 was turned onto her right side she was observed to have facial grimacing, her body tensed up, and she began to guard. Resident #59's wound was observed to be larger than a fist, black, brown, and tan in color with excoriation noted to the surrounding skin and was covered with dressing dated 02/25/25 that was completely saturated with bloody drainage with blood noted on the brief. When the dressing was removed it was noted to have a foul-smelling odor coming from the wound. When Wound Care Nurse #1 and Wound Care Nurse #2 attempted to clean the wound, Resident #59 was unable to tolerate her scheduled dressing change, by crying, grimacing, and saying to stop. During the observation Resident #59 kept saying "ouch, stop, ouch." The wound was covered with an island dressing.

An interview was conducted on 2/27/2025 at 11:12 am with Wound Care Nurse #2. Wound Care Nurse #2 stated she, and Wound Care Nurse #1 rounded on residents daily, performed dressing changes, and measured wounds for residents not seen by the facility's Wound Care Physician. Wound Care Nurse #2 stated on 12/6/2024 Resident #59 had a small wound that changed quickly. Wound Care Nurse #2 stated Resident #59 had experienced pain with dressing changes for approximately the last month and a half. Wound Care Nurse #2 stated she thought it was because she did not want to be touched. Wound Care Nurse #2 verified Resident #59 had not been premedicated for pain prior to wound

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care being provided until 2/26/2025 and could not explain why pain medication had not been ordered with wound care prior to 2/26/2025. Wound Care Nurse #2 could not explain why after Resident #59 was unable to tolerate wound care on 02/26/25 she was not provided with additional pain medication to control her pain that day. Wound Care Nurse #2 stated she and Wound Care Nurse #1 rounded with the Wound Care Physician each week and acknowledged the during the visits Resident #59 reported pain and the wound debridement would be stopped but did not speak to why the pain had not been addressed.

An interview was conducted on 2/27/2025 at 12:47 pm with Nurse #2. Nurse #2 stated he frequently cared for Resident #59. Nurse #2 stated on 11/20/2024 he observed an area of discoloration to Resident #59's coccyx area. Nurse #2 stated he was approached by one of the wound care nurses on 2/26/2025 and informed they could not complete the wound dressing change for Resident #59 due to pain. Nurse #2 stated he had given Resident #59 tramadol pain medication prior to the attempted wound dressing change. Nurse #2 stated he had later seen an order for hydrocodone come through the Electronic Health Record (EHR) prior to him leaving his shift at 3:00 pm on 2/26/2025. Nurse #2 stated he did not reassess Resident #59's pain before he left to see if she needed pain medication.

An interview was conducted on 2/27/2025 at 1:28 pm with Nurse Aide (NA) #3. NA #3 stated she worked Monday through Thursday and every other weekend on dayshift from 7:00 am to 3:00 pm and was always assigned Resident #59. NA

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#3 stated Resident #59 required total care, was incontinent of bowel and bladder, and required turning and repositioning every 2 hours. NA #3 verified Resident #59 had a wound on her coccyx. NA #3 stated Resident #59 complained of pain multiple times throughout the work week over the last one to two months. NA #3 stated she reported Resident #59's complaints of pain to Nurse #2 and was unsure if Resident #59 had received any pain medication.

An interview was conducted on 2/27/2025 at 1:43 pm with Nurse Practitioner (NP) #1. NP #1 stated she had seen Resident #59 on 2/26/2025 after wound care was attempted. NP #1 stated she was told by one of the wound care nurses that Resident #59 was not able to tolerate a dressing change due to pain. NP #1 stated when she asked Resident #59 if she was in pain she said "no, she was okay." NP #1 stated she was not sure why Resident #59 had not received anything for pain, if she had experienced pain with wound care, and stated the facility had a standing order for acetaminophen.

An interview was conducted on 3/3/2025 at 4:03 pm with the Wound Care Physician. The Wound Care Physician stated Resident #59 had a pressure ulcer and he had seen her for approximately two and a half months. The Wound Care Physician stated he used benzocaine (topical pain/numbing agent) to numb Resident #59 prior to attempted/performed debridement. The Wound Care Physician stated her pain was "not bad" and acknowledged that when she had pain, he would stop and use ultrasound mist (a painless, non-contact ultrasound wave delivered through a saline mist to aid in wound healing) instead. The Wound

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F 697	Continued From page 56 Care Physician stated ultrasound mist was just as effective as the debridement. An interview was conducted on 3/5/2025 at 8:51 am with the Director of Nursing (DON). The DON stated she was not aware of Resident #59 having pain with wound dressing changes. The DON stated the facility had a standing order for acetaminophen that could have been given.	F 697		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		3/25/25

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F 761	Continued From page 57 by: Based on observations, and staff and Consultant Pharmacist interviews, the facility failed to date and label insulin pens available for use in 4 of 6 medication carts (medication cart #5, #1, #2 and #6). The findings included: a. An observation of medication cart #5 on 2/27/25 at 10:40 AM with Unit Manager #1 revealed an undated Insulin Lispro pen available for use in the top drawer of the medication cart. A review of the manufacturer's instructions for Insulin Lispro indicated it expired 28 days after first use, and if not refrigerated, it could be stored at a controlled room temperature of up to 86 degrees Fahrenheit or less for up to 28 days. An interview with Unit Manager #1 on 2/27/25 at 10:42 AM revealed the Insulin Lispro should be dated when removed from the refrigerator. Unit Manager #1 stated that the night shift nurse must have taken the insulin pen out of the refrigerator and did not date it, because she had just checked the medication cart after the pharmacist checked it yesterday. b. An observation of medication cart #1 on 2/27/25 at 11:40 AM with Nurse #3 revealed an undated Insulin Glargine pen and two undated Insulin Lispro pens available for use in the top drawer of the medication cart. A review of the manufacturer's instructions for Insulin Glargine indicated it expired 28 days after opening, regardless of whether it was refrigerated. After first use, Insulin Glargine pens could be stored in the refrigerator or at room temperature (up to 86 degrees Fahrenheit) for up to 28 days.	F 761	On 2/27/25, all residents identified to have undated insulin pens were provided new pens by each Unit Manager. Each of these were dated appropriately when placed in the cart available for use. On 3/5/25 an audit of all medication carts was conducted by the Director of Nursing (DON) and nurse Unit Manager (UM). Any noted expired and/or opened undated and/or unlabeled insulin medications were removed and replaced from these medication carts in accordance to manufacturers guidelines and facility protocol. On 3/16/2025 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), and special assigned nurse began education to facility/agency nurses and medication aides on removing and replacing as indicated, expired and/or opened undated and/or unlabeled insulin medications and dating and/or labeling insulin medications when the insulin medication is added to the cart and/or removed from the refrigerator in accordance with manufacturers guidelines and facility protocol. This education will be completed on 03/25/2025. On 3/16/25 the SDC added this education to the new hire packet and agency/contract nurse and medication aide packet. After 3/26/2025, no Contracted Agency/Facility Nursing Staff will be allowed to work until he/she has completed education on removing and	

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F 761	Continued From page 58 An interview with Nurse #3 on 2/27/25 at 11:45 AM revealed the insulin pens lasted 28 days after being taken out of the refrigerator and should have been dated. Nurse #3 stated that she didn't use any of the undated insulin pens on her shift, and did not notice them in the medication cart. She further stated that all nurses were responsible for making sure all insulin pens were dated. c. An observation of medication cart #6 on 2/27/25 at 12:01 PM with Nurse #4 revealed an undated and open Insulin Aspart pen available for use in the top drawer of the medication cart. A review of the manufacturer's instructions for Insulin Aspart indicated it expires 28 days after opening if stored at room temperature or in the refrigerator. An interview with Nurse #4 on 2/27/25 at 12:05 PM revealed she had no idea when the Insulin Aspart pen was taken out of the refrigerator, but it should have been dated because it expired after 28 days. Nurse #4 stated that she didn't notice the undated Insulin Aspart pen in the medication cart. d. An observation of medication cart #2 on 2/27/25 at 1:27 PM with Nurse #5 revealed an undated Insulin Aspart pen available for use in the top drawer of the medication cart. There was also an undated Insulin Glargine pen which was also not labeled with a resident's name. The Insulin Glargine pen was open and available for use in the top drawer of the medication cart. An interview with Nurse #5 on 2/27/25 at 1:30 PM revealed the insulin pens lasted for 28 days after	F 761	replacing as indicated, expired and/or opened undated/unlabeled insulin medications and dating/labeling insulin medications when the insulin medication is added to the medication cart/removed from refrigerator in accordance with manufacturers guidelines and facility protocol. Beginning 3/16/25 the DON, Treatment Nurse, UM, and/or assigned special project nurse will complete monitoring of each medication cart to ensure compliance of removing and replacing as indicated, expired and/or undated/unlabeled insulin medications and dating/labeling insulin medications when the insulin medication is added to the medication cart/removed from refrigerator in accordance with manufacturers guidelines and facility protocol. The DON, Treatment Nurse, unit manager, and/or assigned special project nurse will review each facility medication cart once weekly x3 months to ensure compliance of removing and replacing as indicated, expired and/or undated/unlabeled insulin medications and dating insulin medications when the insulin medication is added to the medication cart/removed from refrigerator in accordance with manufacturers guidelines and facility protocol. Beginning the month of April 2025 and continuing for 3 months, the DON will report the findings of the monitoring: removing and replacing as indicated, expired and/or opened undated/unlabeled	

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F 761	Continued From page 59 opening, and she didn't know when the Insulin Aspart was taken out of the refrigerator and opened. Nurse #5 also stated that she noticed the unlabeled Insulin Glargine this morning, but she didn't administer it to any resident. A phone interview with the Consultant Pharmacist on 2/27/25 at 2:47 PM revealed Insulin Glargine, Insulin Lispro and Insulin Aspart all expired 28 days after they were first used and stored in room temperature. The Consultant Pharmacist stated that the 28-day expiration date started after the insulin pens were taken out of refrigeration. An interview with the Director of Nursing (DON) on 2/27/25 at 2:14 PM revealed that it was her understanding that insulin pens expired 28 days after opening, and not after being taken out of refrigeration. The DON stated that the nurse who opened the insulin pen was responsible for dating it. She also stated that the nurse who obtained the Insulin Glargine from the stock medications should have labeled it with the resident's name and dated it when it was opened. The DON shared that the nurses on the medication carts were responsible for checking the medications for opened dates and labels.	F 761	insulin medications and dating insulin medications when the insulin medication is added to the medication cart/removed from refrigerator in accordance with manufacturers guidelines and facility protocol monthly to quality assurance (QA) committee. The QA Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance to determine the need and/or frequency of the continued Quality Improvement (QI) monitoring to ensure compliance is maintained.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		3/25/25

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F 880	Continued From page 60 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 61 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow their infection control policies and procedures when Nurse Aide (NA) #1 failed to wear the required personal protective equipment (PPE) while toileting a resident (Resident #140) who was on enhanced barrier precautions (EPB) due to a wound and when after cleaning a wound for a resident (Resident #48) Wound Care Nurse #2 failed to doff her gloves, sanitize her hands and don clean gloves prior to applying skin prep around the wound in preparation for the wound dressing on a resident on EBP. This deficiency occurred for 2 of 3 staff members reviewed for infection control practices. 1. Review of the Enhanced Barrier Precautions (EBP) policy and procedure which is part of the Infection Control policies and procedures last updated 03/21/2024 revealed the following:	F 880	On 2/26/25, upon learning of the alleged deficient practice of not wearing a gown when providing care to an Enhanced Barrier Precaution (EBP) Resident, the Director of Nursing provided one on one training for the employee noted to toilet the resident. On 2/26/25, the wound care nurse shared concern related to hand hygiene during wound care with the Director of Nursing. Immediately, the Director of Nursing provide one-on-one training for the employee. On 3/5/25 an audit was conducted by the Director of Nursing and Infection Control Nurse of any resident with a qualifying diagnosis that would require EBP while staff is providing care. On 3/6/25, the Infection Control Nurse inspected each resident’s room to ensure proper EBP	

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F 880	Continued From page 62 Purpose: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Definition: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employ targeted gown, and gloves use during high contact resident care activities. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available near or outside of the resident's room. Face protection may also be needed if performing activity with risk of splash. b. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities include: f. Change of brief/toileting. Enhanced barrier precautions should be used for the duration of the affected residents' stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. A continuous observation on 02/25/25 at 4:36 PM until 4:42 PM revealed a sign outside Resident #140's room indicating she was on EBP. There was a cart on wheels two doors down across the	F 880	signage approved by the Centers for Disease Control was in place. On 3/16/2025 the Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), Infection Preventionist nurse (IPN), and special assigned nurse began education to facility/agency nursing staff on the need to ensure each staff members dons and doffs the appropriate protective gear when providing care in a close proximity to the resident as well as proper hand hygeine. This education will be completed on 03/25/2025. On 3/16/25 the SDC added this education to the new hire packet and agency/contract nursing staff. After 3/26/2025, no nursing staff will be allowed to work until this education is completed. Beginning 3/16/25 Director of Nursing (DON), nurse Unit Manager (UM), Staff Development Coordinator (SDC), Infection Preventionist nurse (IPN), and special assigned nurse will begin monitoring to ensure any resident requiring EBP is provided care by staff who are properly protected. Either at the time of monitoring the use of appropriate EBP or independent of EBP use, proper hand hygiene will be will be monitored at a minimum, 5 random residents week for 4 weeks, then 3 residents for 4 weeks, then 2 residents per week for 4 weeks to ensure compliance with this plan of correction. Beginning the month of April 2025 and continuing for 3 months, the DON will	

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F 880	Continued From page 63 hall with PPE located in the cart. NA #1 was observed in Resident #140's room rolling her in her wheelchair into the bathroom to provide toileting for the resident. NA #1 had on a mask and gloves but no gown and proceeded into the bathroom with the resident to provide assistance with toileting. A few minutes later NA #1 came out of the bathroom with the resident and rolled the resident over to her bedside so she would be up for dinner. An interview on 02/25/25 at 4:44 PM with NA #1 revealed she had not noticed Resident #140 was on EBP and had not seen the sign on the side of the wall next to her door. She stated she was used to residents having a caddie and sign on their door indicating EBP and said she had not noticed the sign on the wall to the side of Resident #140's door. NA #1 further stated she had been educated on EBP and infection control procedures at the facility but didn't see the sign on the wall indicating the resident was on EBP. She indicated she was aware that if a resident was on EBP that she had to wear a gown and gloves while providing resident care. An interview on 02/27/25 at 3:38 PM with the Infection Preventionist revealed she would have expected NA #1 to have worn a gown while providing toileting to Resident #140. She stated the guidelines were very specific about high-contact resident care activities and NA #1 should have worn a gown while providing toileting to Resident #140. An interview on 02/27/25 at 4:01 PM with the Director of Nursing revealed she expected all staff to follow the enhanced barrier precautions when providing resident care activities. She	F 880	report the findings of the monitoring to members quality assurance (QA) committee meeting. The QA Committee will review this monitoring report for further recommendations or follow up as needed for continued compliance.	

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stated she didn't understand why NA #1 had not followed the guidelines when the sign was outside on the wall next to the door for Resident #140.

An interview on 02/27/25 at 4:31 PM with the Administrator revealed it was his expectation that all staff would follow the policy and procedure for EBP during resident care activities.

2. Review of the Hand Hygiene policy and procedure which is part of the Infection Control policies and procedures last updated May 2024 revealed the following:

Policy:
All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations of the facility.

Policy Explanation and Compliance Guidelines:
1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.
2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.
3. Alcohol-based hand rub (ABHR) with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations.

Hand Hygiene Table:

Alcohol based hand rub is preferred:

Before and after handling clean or soiled dressings, linens, etc.
After handling items potentially contaminated with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(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 880	Continued From page 65	F 880		

blood, body fluids, secretions or excretions. When in doubt.

An observation of wound care on 02/26/25 at 9:23 AM with Wound Care Nurse #2 revealed her going into Resident #48's room and cleaning the overbed table with disinfectant wipe. Wound Care Nurse #2 prepared her dressing materials and took them into the room on wax paper to perform the wound care. She positioned the resident, and the resident had a bowel movement, and she proceeded to clean the resident, doffed her gloves, sanitized her hands and applied a clean brief under her. Wound Care Nurse #2 then doffed her gloves, washed her hands with soap and water, donned clean gloves and proceeded to take off the soiled dressing from the resident's sacral wound. She doffed her gloves, sanitized her hands and cleaned the wound with wound cleanser-soaked gauze and dried with a dry gauze. Without doffing her gloves, sanitizing her hands and donning new gloves she proceeded to skin prep the wound border. Wound Care Nurse #2 then doffed her gloves, sanitized her hands and donned new gloves and applied collagen with silver to the wound bed, covered with calcium alginate and applied a clean bordered gauze dressing. She doffed her gloves, sanitized her hands and attached the resident's brief and then cleaned up her supplies and doffed her gloves, sanitized her hands and removed the trash bag from the room.

An interview on 02/26/25 at 2:27 PM with Wound Care Nurse #2 revealed she should have removed her gloves after cleaning the resident's sacral wound, sanitized her hands and applied clean gloves prior to applying skin prep to the wound border. She stated she couldn't believe

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	345186	A. BUILDING _____ B. WING _____	C 03/05/2025

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F 880	Continued From page 66	F 880		

she made that mistake but admitted she was nervous about being watched and just forgot that step.

An interview on 02/27/25 at 3:38 PM with the Infection Preventionist revealed she would have expected Wound Care Nurse #2 to have doffed her gloves after cleansing the wound, sanitized her hands and donned clean gloves prior to applying the skin prep around the wound barrier. She stated anytime you were going from a dirty to clean procedure you would need to doff your gloves, sanitize your hands and don clean gloves before prepping the wound area for the clean dressing.

An interview on 02/27/25 at 4:01 PM with the Director of Nursing revealed she expected Wound Care Nurse #2 to follow the hand hygiene policy while performing wound care to residents. She stated they were constantly providing education to all the staff on infection control procedures.

An interview on 02/27/25 at 4:31 PM with the Administrator revealed it was his expectation that all staff would follow the policy and procedure for hand washing when providing resident care.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345186	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/5/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	**413 WINECOFF SCHOOL ROAD CONCORD, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	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 record review and staff interviews, the facility failed to accurately code a Minimum Data Set assessment in the area of discharge for 1 of 3 residents reviewed for discharge (Resident #147). The findings included: Resident #147 was admitted to the facility on 12/31/24 with diagnoses that included lack of coordination, cognitive communication deficit, and muscle weakness. Review of Resident #147's discharge Minimum Data Set assessment dated 01/16/25 revealed Resident #147 had a planned discharge to a short-term general hospital (acute hospital). Review of Resident #147's progress notes revealed two notes regarding her discharge from the facility. They read as follows: "01/16/25 - Resident discharges home to [assisted living facility] with driver from facility. [The] facility discharge packet [was] discussed and signed." The note was written by LPN Supervisor #1. "01/16/25 - Resident discharged back to [assisted living facility] in facility transportation." The note was written by Social Worker #1. An interview with Nurse Supervisor #1 on 02/26/25 at 10:28 AM revealed she recalled Resident #147 and stated she had been admitted to the facility for a short-term rehabilitation stay. She reported at the end of Resident #147's stay, she was discharged back to the assisted living facility she was at prior to being admitted to the facility. An interview with Social Worker #1 on 02/27/25 at 11:33 AM revealed Resident #147 was discharged back to the assisted living facility she resided at the completion of her short-term rehabilitation stay. She reported Resident #147 did not discharge to the hospital. An interview with MDS Nurse #1 on 02/27/25 at 11:44 AM revealed she remembered Resident #147. She stated that when Resident #147 was discharged from the facility, she went to an assisted living facility. She indicated she must have clicked that Resident #147 discharged to the hospital on her discharge Minimum Data Set assessment in error. During an interview with the Director of Nursing on 02/28/25 at 10:04 AM, she indicated a resident's discharge Minimum Data Set assessment should accurately reflect the location that resident discharged to. She reported Resident #147's discharge Minimum Data Set assessment should have reflected her discharge to

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345186	A. BUILDING: _____ B. WING _____	3/5/2025

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1 an assisted living facility and not a hospital.