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	345513	A. BUILDING _____ B. WING _____	C 03/20/2025

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/17/25 through 3/20/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # F8BN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/17/25 through 3/20/25. Event ID# F8BN11. The following intakes were investigated NC00219012, NC00222325, NC00224993, and NC00228293. 4 of the 4 complaint allegations did not result in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 553		4/17/25

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

Electronically Signed | 04/11/2025

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F 553	Continued From page 1 of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interviews, the facility failed to honor a resident's right to participate in the planning process of the person-centered plan of care for 1 of 4 residents reviewed for care planning (Resident #34). The findings included: Resident #34 was admitted to the facility on 3/26/21. Review of the care plan meeting note dated 4/30/24 revealed a care plan meeting was conducted with Resident #34 and their Responsible Party (RP). Review of the Minimum Data Set (MDS) quarterly assessment dated 2/14/25 revealed Resident #34 was cognitively intact. A review of Resident #34's electronic medical record revealed no further documentation that a care plan meeting had been held or that Resident #34 had been invited to participate in a care plan	F 553	F 553 Right to Participate in Care Planning On 3/20/2025, a care plan meeting was scheduled by the social worker for Resident #34. A written invitation was provided to Resident #34 and the Resident Representative (RR) by the social worker with documentation in the electronic medical record. On 4/1/2025, the Director of Nursing (DON) initiated an audit of all residents' most recent care plan meetings to ensure that a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or RR provided with a written invitation to attend the care plan meeting with documentation in the electronic medical record. The DON and/or the social worker will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting for any resident or RR who was not provided with a written	

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F 553	Continued From page 2 meeting in the time between the 4/30/24 care plan meeting through 3/17/25. During an interview on 3/17/25 at 12:47 pm Resident #34 reported she was unable to remember the last time the facility invited her to attend a care plan meeting. Resident #34 stated she would be interested in attending a care plan meeting to review her medications and other concerns but it had not been offered. An interview was conducted with the Social Worker on 3/18/25 at 2:05 pm. The Social Worker revealed she started working at the facility in August of 2024 and she had not had a care plan meeting for Resident #34. The Social Worker stated long-term care residents were to have a care plan meeting every 3 months or more often if requested. The Social Worker stated she had been trying to keep track of the process of scheduling care plan meetings but she stated she was not provided with an actual list of resident care plan meetings that were due. The MDS Nurse was interviewed on 3/18/25 at 2:37 pm who revealed it was not her normal practice to provide the Social Worker with a list of residents who required a care plan meeting based on the MDS assessments. The MDS Nurse stated a resident care plan would be automatically updated when she opened them and each department would have to review and sign off on their sections. She stated she did not participate in the care plan meeting. The MDS Nurse stated that once all the departments have completed their sections of the care plan, she would complete the nursing portions and sign off that the care plan had been reviewed. The MDS Nurse stated she did not confirm that the Social	F 553	invitation per facility protocol. The audit will be completed by 4/17/2025. On 4/9/2025, the administrator initiated an in-service with the Director of Nursing (DON), Minimum Data Set (MDS) Nurse, and social worker regarding the Resident Care Plan Process with emphasis on (1) resident right to participate in the planning process (2) timely scheduling of care plan meetings following admission, with changes in plan of care and/or quarterly and (3) providing the resident and/or resident representative a written invitation to care plan meeting with documentation in the electronic record. The in-service will be completed by 4/17/2025. All newly hired DONs, MDS nurses, or social workers will be educated by the administrator during orientation. The administrator and/or DON the will audit 5 care plan meetings to include newly admitted/re-admitted residents and/or scheduled quarterly reviews weekly x 4 weeks, then monthly x 1 month, utilizing the Care Plan Meeting Audit tool to ensure a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or RR were provided a written invitation to the care plan meeting with documentation in the electronic record. The DON will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting per facility guidelines, providing a written invitation to the resident and/or RR with documentation in the electronic record,	

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F 553	Continued From page 3 Worker scheduled and held a care plan meeting for Resident #34 before she completed the care plan review. An interview was conducted with the Administrator on 3/20/25 at 1:44 pm who revealed the MDS Nurse should have provided the Social Worker with a list of residents that needed to have a care plan meeting scheduled when the quarterly care plans were reviewed.	F 553	and/or re-education of staff. The administrator will review the Care Plan Meeting audit tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The administrator will forward the results of the Care Plan Meeting Audit tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561		4/17/25

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F 561	Continued From page 4 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff and Medical Director interviews, the facility failed to honor a resident with a diagnosis of type I diabetes the choice to use an insulin pump (small, wearable device that delivers doses of insulin at specific times and are an alternative to multiple daily injections) as preferred for 1 of 1 resident (Resident #29) reviewed for choices. Findings included: Resident #29 was readmitted to the facility on 11/8/24. The quarterly Minimum Data Set (MDS) assessment dated 2/1/25 revealed that Resident #29 was cognitively intact and was independent or required supervision with most activities of daily living (ADL). Resident #29's care plan dated 10/13/23 revealed Resident #29 had diabetes mellitus and the potential for complications of hyper/hypoglycemia such diabetic ketoacidosis (DKA). The care plan was revised on 12/30/24 to include that Resident #29 had a potential for fluid volume deficit due to a history of dehydration requiring intravenous fluids, nausea and vomiting, acute kidney injury, and diabetic ketoacidosis due to hyperglycemia.	F 561	F 561 Self Determination On 4/11/2025, the Unit Manager contacted the endocrinologist for Resident #29 and received clarification that insulin pump was to be started after discharge from facility. Resident #29 has a follow up appointment on 6/30/2025 with the endocrinologist. On 4/11/2025, the Director of Nursing (DON) and Unit Manager completed an audit of all endocrinology consults for the past 3 months. This is to identify any recommendations for the use of insulin pumps per resident preference, and to ensure the resident is assessed for self-administration safety and/or notification of the physician for further recommendations when indicated. There were no additional concerns noted during the audit. Beginning on 4/17/25, the unit manager will review all consult recommendations with the provider for approval and to ensure that recommendations are initiated timely or notification of the consulting physician when the initial	

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F 561	Continued From page 5 Review of physician orders for Resident #29 revealed that she received the following insulin orders: - 2/25/25: Insulin Lispro Injection Solution 100 unit/milliliter (mL) Inject as per sliding scale: if 200 - 250 = 2 unit; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 500 = 10 units if 400 and over give 10 units and call the physician, subcutaneously four times a day for diabetes - 2/26/25: Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/mL Inject 20 units subcutaneously one time a day for diabetes Review of a Medical Director Encounter note dated 2/25/25 revealed that Resident #29 had a follow up endocrinology appointment today, and the use of an insulin pump with the hope of restarting would be readdressed. Review of an Endocrine Follow-up visit dated 2/26/25 revealed that the consultation was requested by the Medical Director. She had been in and out of hospitals over the past few months due to her Parkinson's and blood pressure. Resident #29 was not allowed to use an insulin pump at the nursing facility. However, she had been hospitalized twice in the past year for DKA, and the blood sugars were not controlled. The plan was to start Resident #29 on continuous glucose monitor, since she will be moving to an independent facility. Review of an Medical Director Encounter note dated 2/28/25 revealed that Resident #29 went to the endocrinologist on 2/26/25 for a follow up. Resident #29 requested the use of an insulin pump. The endocrinologist office ordered one for her and would provide her with proper training.	F 561	recommendations cannot be implemented for further review. On 4/14/2025, the DON notified the unit manager of responsibility to review all consult recommendations with the provider. On 4/11/2025, the DON initiated an in-service with all nurses regarding Following Physician□s Orders and Recommendations with emphasis on ensuring the physician reviews all consult recommendations to include use of insulin pumps and initiates orders per provider recommendations when indicated and/or notification of the physician when orders cannot be implemented for further recommendations. The in-service will be completed by 4/17/2025. After 4/17/2025, any nurse who has not completed the in-service will be educated prior to the next scheduled work shift by the unit manager or the DON. All newly hired nurses will be in-serviced during orientation with the unit manager and/or the DON regarding Following Physician□s Orders and Recommendations with emphasis on ensuring the physician reviews all consult recommendations to include use of insulin pumps and initiates orders per provider recommendations when indicated and/or notification of the physician when orders cannot be implemented for further recommendations. The Minimum Data Set (MDS) Nurse, charge nurse, and/or the unit manager will	

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F 561	Continued From page 6 An interview was conducted with Resident #29 on 03/17/25 11:57 AM. She revealed that she had an insulin pump prior to admission, but the facility would not allow her to use it due to "policy." Resident #29 stated that she was a very brittle diabetic, and her endocrinologist had spoken to facility staff about the use of an insulin pump. All the supplies could be sent to her directly, and she would use the pump on her own. The Medical Director was interviewed on 3/18/25 at 1:49 PM. She revealed that Resident #29 used to be on an insulin pump, so when she went into DKA in the hospital or when she was admitted to the facility, the insulin pump was replaced with short-/long-acting insulin for better blood sugar control. The Medical Director recently referred Resident #29 to endocrinology to prepare her for a planned discharge. Resident #29 was seen on 2/26/25 and was last seen by the endocrinologist over a year ago. The Medical Director stated that the facility had a continuous glucose monitor (a wearable device by the user that tracks blood sugar every few minutes 24 hours per day) in the building, but Resident #29 was not using it yet because she was waiting for the insulin pump to arrive. The endocrinologist office ordered the insulin pump, and Resident #29 required reeducation on its use. The Medical Director stated she had not yet received permission from corporate for Resident #29 to use the insulin pump. She further stated that she was aware Resident #29 wanted an insulin pump for the last 6 months. If Resident #29 received an insulin pump education and received it from the endocrinologist, then she would be safe to administer the insulin pump.	F 561	utilize the Consult Audit tool to audit all endocrinology consults including Resident #29 weekly x 4 weeks, then monthly x 1 month to ensure orders and/or recommendations are initiated timely, obtaining clarification orders when indicated, and/or the physician notified when the orders cannot be initiated for further recommendations. All areas of concern will be immediately addressed by the Charge Nurse, Unit Manager, and/or the DON to include ensuring orders and/or recommendations are initiated timely, obtaining clarification orders when indicated, the physician is notified when the orders cannot be initiated for further recommendations, and/or re-education of staff as appropriate. The DON will review the Consult Audit tool weekly for 4 weeks, then monthly 1 month to ensure all areas of concern are addressed. The Administrator will forward the results of the Consult Audit tool to the Quality Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Consult Audit tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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An interview was conducted with the Regional Vice President on 3/18/25 at 2:21 PM. He stated that the facility did not have a policy on insulin administration, and if there was not a policy related to an insulin pump, then that meant the facility did not allow that specific medical device. The Regional Vice President indicated he was under the impression that an insulin pump was brought up by Resident #29 due to her planned discharge. However, Resident #29 did not approve of the facility where she was to be transferred. Now that she remained in the facility, the insulin pump conversation was on pause.

During a follow-up interview with Resident #29 on 3/18/25 at 2:42 PM, she revealed that she administered the insulin pump on her own for 5 years prior to admission and received multiple education opportunities. Currently, she was waiting for an independent handicap apartment to be discharged from the facility. Resident #29 stated that she discussed the insulin pump with the Medical Director many times, and she recommended that it was a medical necessity. Resident #29 stated that nursing staff did not know how to respond with insulin to her brittle blood sugar readings. She did refuse certain insulin dosages at times to prevent hypoglycemia.

During a follow-up interview with the Medical Director on 3/19/25 at 2:08 PM, she stated that the insulin pump for Resident #29 was a preference, and not a medical necessity.

The Regional Assistant Vice President (AVP) of Health Services was interviewed on 3/19/25 at 8:33 AM. She revealed that she was contacted by the Director of Nursing (DON) 2 weeks ago about how to get an insulin pump for Resident

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#29 because the endocrinologist was going to order a pump and continuous glucose monitor upon discharge. The Regional AVP of Health Services stated that she was unsure how to attain these medical devices, provide education to the resident and staff, and which vendor source to use. Home health was supposed to provide Resident #29 with education about the insulin pump when she admitted to another facility. She indicated that a resident could obtain an insulin pump if they were admitted with one, since they already had a carrier for the device. The company's pharmacy did not provide insulin pumps. If Resident #29 requested an insulin pump 6 months ago, the facility would have made efforts to fulfill this medical device request. If facility staff spoke directly to pharmacy, then this request would be denied without further investigation. The Regional AVP of Health Services said she performed more investigation since contacted by the DON, and she found that if the resident was not admitted with an insulin pump but expressed great interest to acquire one, the facility would accommodate the request as best as possible.

During an interview with the DON on 3/19/25 at 2:44 PM, she revealed that the first time she heard about Resident #29 wanting an insulin pump was several weeks ago. Resident #29 had an appointment with the Endocrinologist on 2/26/25. The DON contacted the endocrinology office to speak with the provider, which took a couple of days for a return phone call. The provider told the DON that Resident #29 could use the insulin pump upon discharge from the facility. The DON told the provider that she needed to speak with the Medical Director on the use of this medical device. The provider stated

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F 561	Continued From page 9 that Resident #29 needed to come back to the office to receive the authorization and education on the insulin pump, and it would be a few weeks before she would receive the supplies in the mail. The DON stated she spoke with the Medical Director, who was aware of the entire situation and was working on getting Resident #29 the insulin pump. The DON then left it with the Medical Director because she was already working on the request. The DON indicated that if there was not a problem with implementing the insulin pump, and the facility approved, then Resident #29 should be able to use that preferred medical device. The Administrator was interviewed on 3/19/25 at 3:18 PM. He revealed that Resident #29's preference for an insulin pump should have been fulfilled in a timely manner.	F 561		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		4/17/25

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§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and

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F 585	Continued From page 11 coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to provide a written	F 585	F 585 Grievances	

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	345513	A. BUILDING _____ B. WING _____	C 03/20/2025

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F 585	Continued From page 12 grievance decision to a resident for 1 of 1 resident reviewed for grievances (Resident #24). The findings included: Resident #24 was admitted to the facility on 7/26/24. The Minimum Data Set (MDS) quarterly assessment dated 12/23/24 revealed Resident #24 was cognitively intact. Review of the Facility Concern/Grievance Form dated 1/20/25 revealed Resident #24 had reported concerns to the Social Worker regarding staff language in hall and not getting along with a roommate and possible room change. The grievance was assigned to the Director of Nursing (DON) on 1/20/25 with an expected return due date of 1/23/25. The actions taken section, which was completed by the DON, noted that she spoke with Resident #24 related to reported concerns and that she met with staff members related to customer service, mindfulness of environment, and professionalism. The DON further noted the Social Worker was aware of Resident #24's request for a room change. The Facility Concern/Grievance Form noted it was to be returned to the Administrator after the investigation was completed. The grievance resolution section was not completed and the grievance was not signed by the facility's grievance officer. Review of Resident #24's progress notes dated 1/20/25 through 3/18/25 revealed no documentation regarding the discussion of the room change requested on the 1/20/25 grievance form.	F 585	On 4/10/2025, the Administrator provided a written response and follow up to the grievance for Resident #24 regarding staff language in the hall, getting along with roommate, and possible room change. On 4/7/2025, the Director of Nursing (DON) initiated an audit of all grievances for the past 60 days to ensure all grievances were investigated and a review of the grievance findings was completed with the resident and/or resident representative to include a written grievance decision when requested. The audit will be completed by 4/17/2025. The DON and/or Social Worker will address all concerns during the audit to include completing an investigation with grievance form and appropriate follow-up as needed. On 4/7/2025, the Social Worker and Minimum Data Set (MDS) Nurse initiated resident questionnaires with all alert and oriented residents regarding concerns to identify any resident concerns that had not been addressed by the facility. The questionnaires will be completed by 4/17/2025. The Social Worker and/or the Administrator will address all concerns identified during the audit to include completion of a grievance form, investigation of concern, and a review of the grievance findings was completed with the resident and/or resident representative to include a written grievance decision when requested. On 4/9/2025, the Administrator, Director of	

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F 585	Continued From page 13 An interview was conducted with Resident #24 on 3/18/25 at 12:37 pm who reported she had talked to someone a few months ago about a room change because the roommate kept her awake at night and that the staff language in the hall was not appropriate. Resident #24 stated she did not know what the outcome of her reported concern was because she was still in the same room and the staff were still loud in the hallways. During an interview on 3/18/25 at 3:43 pm with the Social Worker she revealed that when Resident #24 reported the grievance she talked about a possible room change but did not recall her requesting the room to be changed at the time the grievance was reported. The Social Worker stated the DON did not tell her that Resident #24 wanted to change her room after the DON met with Resident #24. She stated the grievance form was to be returned to the grievance officer once the DON completed the investigation for Resident #24's concerns. The Social Worker stated the previous Administrator was the grievance officer at the time Resident #24's Facility Concern/Grievance Form was received and was responsible to provide the written grievance resolution to Resident #24. An interview was conducted with the DON on 3/19/25 at 2:11 pm who revealed she did not follow up with the Social Worker about the room change request after meeting with Resident #24 because she thought the Social Worker was aware. The DON stated she met with staff when Resident #24's concerns were reported but she did not follow up with Resident #24 to discuss steps taken towards the resolution of the concerns or if the concerns were resolved. The	F 585	Nursing (DON), and the Social Worker were in-serviced by the Clinical Consultant regarding Resident Grievance Policy and Guidelines to include the Administrator's responsibility to ensure all grievances are investigated, completion of grievance form, review of the grievance findings completed with the resident and/or resident representative to include a written grievance decision when requested. All newly hired Administrators, Directors of Nursing (DON), and Social Workers will be educated during orientation by the Staff Development Coordinator. The Administrator will forward the results of the Grievance Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 585	Continued From page 14 DON stated she believed she returned Resident #24's grievance to the Social Worker. The DON stated she did not recall seeing the form was to be returned to the Administrator once she completed her portion. A telephone interview was conducted on 3/19/25 at 2:30 pm with the previous Administrator who revealed she was the facility grievance officer at the time of Resident #24's concern. She stated she was responsible for providing the written resolution of grievance to the residents once the concern was fully investigated. She reported at the time she had left the facility in March 2025, the DON still had not returned several grievance forms and Resident #24's grievance could have been one that was outstanding. The previous Administrator stated she would have reviewed the grievance investigation when it was completed and the resolution would have been completed. She stated if Resident #24 confirmed to the DON that she wanted a room change it would have been discussed and implemented. The previous Administrator stated she did not recall Resident #24's grievance being brought to her to complete the resolution or address the requested room change.	F 585		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and	F 685		4/17/25

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F 685	Continued From page 15 §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, staff, and Responsible Party interviews, the facility failed to ensure that a resident with reported hearing difficulties was evaluated for treatment and services to maintain his hearing ability for 1 of 1 resident reviewed for vision and hearing (Resident #14). The findings included: Resident #14 was admitted to the facility on 7/19/22 with diagnoses which included unspecified sensorineural hearing loss (hearing loss caused by damage to the inner ear or nerve from the ear to the brain with treatment that included hearing aids). Review of the Minimum Data Set (MDS) quarterly assessment dated 2/10/25 revealed Resident #14 had severe cognitive impairment and was coded for moderate hearing difficulty and was not coded for the use of hearing aids. The care plan last reviewed on 3/05/25 revealed Resident #14 had a care plan in place for auditory alteration characterized by decreased hearing in the left and right ears related to aging process. Interventions included getting the resident's attention before speaking and moving the resident to a low-noise place or remove as much background noise before speaking with the resident.	F 685	F 685 Treatment/Devices to Maintain Hearing/Vision On 4/4/2025, the Unit Manager scheduled an appointment for Resident #14 to be evaluated by audiology on 4/9/2025. Resident #14 and the Resident Representative (RR) were notified of the scheduled appointment by the Unit Manager with documentation in the electronic medical record. On 4/4/2025, the Minimum Data Set (MDS) Nurse initiated an audit of all residents coded for hearing difficulties on the most recent MDS assessment. The audit was initiated to ensure all residents coded for hearing difficulties have been evaluated by an audiologist or have an appointment scheduled to be evaluated by an audiologist per preference. The audit will be completed by 4/17/2025. Any concerns identified during the audit will be immediately addressed by the Unit Manager and/or the Social Worker to include notification of the provider, scheduling an audiology appointment when indicated, resident/RR notification of the appointment with documentation in the electronic record, and education of staff.	

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F 685	Continued From page 16 Review of Resident #14's electronic health record revealed no audiology consultations (healthcare professionals that identify, assess, and manage hearing issues) were scheduled or completed regarding Resident #14's hearing difficulties. An interview and observation were conducted on 3/17/25 at 10:50 am with Resident #14. Resident #14 reported he was very hard of hearing and this surveyor needed to speak louder if he was to hear what was being said. This surveyor had to move about 2 inches from Resident #14's left ear for Resident #14 to hear the questions. Resident #14 stated he found it hard to listen to his television so he just looked at the screen without the volume up. Resident #14 stated he did not remember anyone asking him about his hearing or getting him tested for hearing aids but stated he would like to have them. During an interview on 3/17/25 at 11:00 am Nurse Aide (NA) #1 revealed he knew Resident #14 well and was assigned to his care at times. NA #1 stated Resident #14 was very hard of hearing. NA #1 stated he did not recall Resident #14 ever having hearing aids he just knew he needed to talk very loud for the resident to hear him. A telephone interview was conducted with Resident #14's Responsible Party (RP) on 3/17/25 at 2:27 pm. The RP stated she was aware of Resident #14's hearing loss but did not know if he had any previous hearing tests or hearing aids prior to admission to the facility. An interview was conducted on 3/18/25 at 2:42 pm with the MDS Nurse who revealed she completed Resident #14's MDS assessment and	F 685	On 4/4/2025, the Social Worker and MDS Nurse initiated questionnaires with all alert and oriented residents to identify any resident reporting hearing difficulties to ensure an evaluation for hearing has been completed or scheduled per resident preference. The questionnaires will be completed by 4/17/25. The Social Worker and/or MDS Nurse will address all concerns identified during the audit to include notification of the provider, scheduling an audiology appointment when indicated, resident/RR notification of the appointment with documentation in the electronic record, and education of staff. On 4/4/2025, the Clinical Consultant completed an in-service with the Administrator and the Minimum Data Set (MDS) Nurse regarding Requests/Referrals for Medical Appointments which included ensuring the Administrator, Social Worker, Unit Manager, and/or the Director of Nursing (DON) were notified for any resident coded as having hearing difficulties to ensure requests and/or referrals for hearing services have been scheduled as appropriate. On 4/9/2025, the Administrator initiated an in-service with the Scheduler/Transport, Social Worker, Director of Nursing (DON), MDS Nurse, Unit Manager, and licensed nurses regarding Requests/Referrals for Medical Appointments with emphasis on ensuring residents receive treatment and assistive devices for hearing services as	

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F 685	Continued From page 17 coded him for hearing impairment. She stated if she felt the hearing loss was chronic or their baseline hearing she would not normally discuss it with the interdisciplinary team. The MDS Nurse stated the facility had the availability to have an audiology consult conducted in the facility and the Social Worker would be responsible for the scheduling. The MDS Nurse stated she made sure Resident #14 had a care plan in place for hearing loss but she did not discuss the need for an audiology consult with the Social Worker because she felt it was chronic and his baseline. During an interview with the Social Worker on 3/18/25 at 3:38 pm she revealed she had been employed at the facility for approximately six months, and she was not aware Resident #14 was hard of hearing. The Social Worker stated she was not notified by the MDS Nurse that Resident #14 had hearing impairment so she did not schedule him for an audiology consult at the facility. The Social Worker stated she was unable to locate any documentation that Resident #14 had been seen by the audiology provider and she stated she would have scheduled the consultation had she been notified of the need. An interview was conducted on 3/20/25 at 1:38 pm with the Administrator who revealed the MDS Nurse should have provided the hearing impairment findings for Resident #14 to the Social Worker so the audiology consult could have been completed to determine if there was a need for hearing aids or other treatment options.	F 685	applicable, that requests and/or referrals for hearing services were completed timely per physician order and resident preference. The in-service will be completed by 4/17/2025. All newly hired Directors of Nursing (DONs), scheduler/transporters, social workers, MDS Nurses, and/or unit managers will receive the in-service on Requests/Referrals for Medical Appointments during orientation by the administrator. 5 MDS assessments will be reviewed by the unit manager and/or the DON weekly x 4 weeks, monthly x 1 month, utilizing the Resident Appointment Audit tool to ensure any resident that reports difficulty hearing or is coded for difficulty hearing on the MDS assessment has an evaluation or follow up appointment scheduled with audiology as appropriate. Any concerns identified will be immediately addressed by the unit manager and/or the DON scheduling evaluations and re-training staff as appropriate. The administrator will review the Resident Appointment Audit tool. weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The administrator will present the findings of the Resident Appointment Audit tool. to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency	

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F 685	Continued From page 18	F 685	of monitoring.	
F 761 SS=D	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 by: Based on record review, observation, and staff and Pharmacist interviews, the facility failed to remove expired medications stored for use in the medication storage room 1 of 1 medication storage room observed. The findings included:	F 761	F 761 Label/Store Drugs and Biologicals On 3/19/2025, the Director of Nursing (DON) discarded twenty-two (22) lidocaine 4% pain relief patches from the medication storage room with an expiration date of 2/25/2025.	4/17/25

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F 761	Continued From page 19 During an observation on 3/19/25 at 7:52 am of the medication storage room with the Director of Nursing (DON) the following was observed: Twenty-two (22) lidocaine 4% pain relief patches with an expiration date of 2/25/25. The expired lidocaine 4% pain relief patches were located in a bin on the counter in the medication storage room with multiple bags of unexpired lidocaine 4% pain relief patches. The expiration date was confirmed by the DON. A telephone interview was conducted with the Pharmacist on 3/20/25 at 10:08 am who revealed the facility was able to return expired medications to the pharmacy every day. She stated the facility would have to put the expired medications in the pharmacy tote when they were ready to be returned and would be picked up when the daily delivery was made. An interview was conducted on 3/19/25 at 2:13 pm with the DON who stated the facility did not have anyone who was assigned or responsible to make sure expired medications were removed from the medication storage room. The DON stated she did not notice that the pain patches were expired, but she stated it was possible that the pain patches were supposed to be sent back to the pharmacy. The DON stated medications were able to be returned to the pharmacy a few times a week but they may have missed sending the pain patches back. During an interview with the Administrator on 3/20/25 at 1:49 pm he revealed the Director of Nursing and the nursing team were responsible	F 761	On 4/1/2025, the Unit Manager and DON initiated an audit of all medication storage rooms to identify any expired medications including lidocaine 4% pain relief patches. The audit will be completed by 4/17/2025. Any items found to be expired will be immediately discarded and/or returned to pharmacy appropriately per policy during the audit by the Unit Manager and/or the DON. Beginning 4/17/25, the unit manager and/or charge nurse will conduct random audits to monitor compliance for medication storage. On 4/14/2025, the DON notified the unit manager and charge nurse of responsibility to monitor ongoing medication storage compliance. On 4/1/2025, the DON initiated an in-service with all nurses and medication aides regarding Medication Storage regarding checking medication rooms for expired medications, discarding expired items, and/or returning expired medications to pharmacy appropriately per policy. This in-service will be completed by 4/17/2025. After 4/17/2025, any nurse or medication aide who has not received the in-service be educated by the unit manager or the DON prior to the next scheduled work shift. All newly hired nurses and medication aides will be in-serviced during orientation by the Unit Manager and/or the DON regarding checking medication rooms for expired	

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F 761	Continued From page 20 for ensuring expired medications were removed from the medication room.	F 761	medications, discarding expired items, and/or returning expired medications to pharmacy appropriately per policy. The Unit Manager and/or the Charge Nurse will audit all medication storage rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Storage Audit tool to identify any expired medications including lidocaine 4% pain relief patches. Any items found to be expired will be immediately discarded and/or returned to pharmacy appropriately per policy, with staff re-training as applicable by the Unit Manager and/or the Charge Nurse. The Director of Nursing (DON) will review the Medication Storage Audit tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of Medication Storage Audit tool to the Quality Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		4/17/25

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F 842	Continued From page 21	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained

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F 842	Continued From page 22 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to ensure a medical record was accurate regarding medication administration and wound treatment. This was for 2 of 20 sampled residents whose medical records were reviewed (Resident #29 and Resident #7). Findings included: 1. Resident #29 was readmitted to the facility on 11/8/24 with a diagnosis of hypotension. The quarterly Minimum Data Set (MDS) assessment dated 2/1/25 revealed that Resident #29 was cognitively intact. The physician orders for Resident #29 revealed	F 842	F 842 Resident Records- Identifiable Information On 3/20/25, the Director of Nursing (DON) notified the provider that resident #29 may have received Midodrine outside of designated parameters with no new orders. Resident #29 was assessed with no negative findings. On 3/19/2025, the Treatment Nurse received orders from the physician to discontinue wound vac for resident #7 and apply wet to dry dressing. On 4/7/25, the Unit Manager, Minimum Data Set (MDS) nurse and the charge nurse initiated an audit of electronic	

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F 842	Continued From page 23 an order dated 11/21/24 for Midodrine HCl Oral Tablet 10 milligrams (mg) 1 tablet by mouth three times a day (8:00 AM, 12:00 PM, and 5:00 PM) for hypotension, take blood pressure (BP) in a sitting position, and hold if the systolic blood pressure (the top number in a BP reading that measures the pressure in the arteries when the heart beats) is greater than 120. A Pharmacist's Report to Nursing dated 2/24/25 revealed that the Midodrine medication was documented as administered to Resident #29 on the following dates per the February 2025 medication administration record (MAR) even though the systolic BP was greater than 120: - 2/1/25: 138/70 (8:00 AM), 145/82 (12:00 PM) - 2/2/25: 128/78 (8:00 AM), 145/84 (12:00 PM), 133/80 (5:00 PM) - 2/7/25: 179/95 (8:00 AM), 171/92 (12:00 PM), 165/80 (5:00 PM) - 2/8/25: 127/78 (8:00 AM), 145/86 (12:00 PM) - 2/9/25: 141/65 (8:00 AM) - 2/12/25: 145/77 (8:00 AM), 139/87 (12:00 PM) - 2/15/25: 145/83 (8:00 AM) - 2/19/25: 124/72 (8:00 AM) - 2/20/25: 155/73 (8:00 AM) - 2/21/25: 170/70 (8:00 AM), 127/76 (5:00 PM) - 2/22/25: 126/74 (8:00 AM), 132/76 (12:00 PM) - 2/23/25: 126/76 (8:00 AM), 126/76 (12:00 PM) The February 2025 MAR revealed the following nurses were responsible for the documentation that Midodrine was administered to Resident #29 even though the systolic BP was greater than 120: - 2/1/25: Nurse #5 - 2/2/25: Nurse #6 - 2/7/25: Nurse #8 (8:00 AM and 12:00 PM), Nurse #6 (5:00 PM)	F 842	medical record (eMAR) for any resident receiving blood pressure medication with parameters designated for administering for the past 30 days. This audit is to ensure the nurse and/or medication aid obtained blood pressure and administered medication per physician order to include medications with parameters. The Director of Nursing (DON) will address all concerns identified during the audit to include assessment of the residents, notification of the physician when indicated and education of staff. The audit will be completed by 4/17/25. On 4/7/25, the Director of Nursing completed an audit of electronic treatment record (eTAR) for all residents with orders for wound vacs for the past 30 days. This audit is to ensure the nurse accurately documents the use of the wound vac and validates the wound vac is functioning properly. There were no additional concerns identified. On 4/7/2025, the Director of Nursing (DON) initiated an in-service with all nurses and medication aides regarding Following Physician Orders with emphasis on obtaining vitals prior to administering medications with parameters, holding medications that exceed designated parameters, accuracy of documentation of medications administered or validation reason medication was not administered. The in-service will be completed by 4/17/25. After 4/17/25, any nurse or medication aid who has not received the in-service be educated by the unit manager or DON prior to the next	

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F 842	Continued From page 24 - 2/8/25: Nurse #6 - 2/9/25: Nurse #9 - 2/12/25: Nurse #6 - 2/15/25: Nurse #5 - 2/19/25: Nurse #2 - 2/20/25: Nurse #2 - 2/21/25: Nurse #6 - 2/22/25: Nurse#2 - 2/23/25: Nurse #2 - 2/27/25: 126/76 (8:00 AM), 126/76 (12:00 PM), 126/76 (5:00 PM) The March 2025 MAR revealed the following BP values and nurses who documented they administered Midodrine to Resident #29 even though the systolic BP was greater than 120: - 3/2/25: 131/85 at 5:00 PM by Nurse #6 - 3/4/25: 138/84 (8:00 AM) and 162/87 (12:00 PM) both by Nurse #10 - 3/6/25: 123/79 at 8:00 AM by Nurse #6 - 3/7/25: 163/89 (8:00 AM), 163/89 (12:00 PM), 192/98 (5:00 PM) all by Nurse #8 - 3/8/25: 140/88 at 8:00 AM by Nurse #11 - 3/9/25: 126/74 (8:00 AM) and 126/74 (12:00 PM) both by Nurse #3 An interview was conducted with Resident #29 on 3/20/25 at 12:31 PM. She was able to describe the appearance of the Midodrine tablet and indicated she would not have taken Midodrine if anyone attempted to give it to her with a systolic BP higher than 120. Nurse #6 was interviewed via telephone on 3/20/25 at 11:59 AM. She revealed that if a medication order states to hold if systolic BP was greater than 120, she would not administer the medication. Nurse #6 stated that Resident #29's BP was taken right before Midodrine was	F 842	scheduled work shift. All newly hired nurses and medication aides will be educated during orientation by the unit manager or the Director of Nursing. The unit managers will complete random audits of MAR and TAR documentation for accuracy to include treatments and administering meds with parameters to ensure ongoing compliance with accuracy of documentation. On 4/14/2025, the DON informed the unit managers of the responsibility to monitor compliance and accuracy of documentation with ongoing monitoring of MAR and TAR documentation to include use of wound vacs and medications with parameters. On 4/7/2025, the DON initiated an in-service with all nurses regarding TAR Documentation with emphasis on completing treatments per physician orders with accurate documentation on eTAR of treatment completed or accurate coding for reason treatment was not completed with provider notification. The in-service also included visual inspection for validation for proper functioning and settings for any resident with a wound vac order. The in-service will be completed by 4/17/2025. After 4/17/25, any nurse who has not received the in-service be educated by the unit manager or DON prior to the next scheduled work shift. All newly hired nurses will be in-serviced during orientation by the unit manager and/or the DON regarding TAR	

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F 842	Continued From page 25	F 842		

scheduled to be given. For the dates that she documented Midodrine was given, even though Resident #29's systolic BP was greater than 120, she did not administer the medication. She stated that she made the wrong choice of coding on the February and March MARs in error. Nurse #6 indicated that instead of coding Midodrine as given, she should have chosen "5," which meant "Hold/See Nurses Notes." She stated she needed to pay more attention and read the MAR more closely.

An interview was conducted with Nurse #5 on 3/20/25 at 12:10 PM. She revealed that if an order with parameters for Midodrine was initiated, then the medication should be held if the systolic BP was greater than 120. Nurse #5 stated that for all entries on the MARs that indicated it was given even though Resident #29's systolic BP was higher than 120, they were entered in error. She should have chosen the action as "5" for "Hold/See Nurses Notes." Nurse #5 stated that Resident #29 was alert and oriented and very familiar with her own medication regimen.

Nurse #2 was interviewed on 3/20/25 at 12:35 PM. She revealed that if an order stated to hold Midodrine if systolic BP was greater than 120, she would hold the medication and not administer it. Nurse #2 indicated that in the MAR there was an option where the BP value could be entered and an opportunity to choose if the medication was held. Nurse #2 indicated that the Midodrine was not given to Resident #29 when her systolic BP was greater than 120. She stated that the electronic medical record (EMR) was new to her, and the reason why administered was chosen instead of hold was due to clerical errors. She indicated that Resident #29 was aware of her

Documentation.

The Unit Manager, Minimum Data Set (MDS) Nurse, and/or charge nurse will complete 5 Med Pass Audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurse or medication aide administered medications per physician orders to include obtaining vitals prior to administering medications with parameters, holding medications that exceed designated parameters, accurately documented medications administered, or a validation reason medication was not administered. The unit manager, MDS nurse and/or charge nurse will address all concerns identified during the audit to include obtaining vitals or assessment of the resident when indicated and re-training of staff. The DON will review the Med Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

The Unit Manager, MDS Nurse, and/or the charge nurse will complete observations of all residents with orders for wound vacs and eTAR documentation twice weekly x 4 weeks then monthly x 1 month utilizing the Treatment Administration Audit Report. This audit is to ensure the nurse completes treatment per physician orders with accurate documentation on eTAR of treatment completed or accurate coding for reason treatment was not completed with provider notification and that the nurse visually inspects proper functioning and settings for any resident with a wound vac

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F 842	Continued From page 26 medication orders and any parameters. An interview was conducted via telephone with Nurse #9 on 3/20/25 at 12:48 PM. She revealed that she did not administer the Midodrine on 2/9/25 at 8:00 AM. It must have been a clerical error. Nurse #9 indicated that Resident #29 was alert and oriented, very involved in her care, and would not accept the medication if her systolic BP was more than 120. During a telephone interview with Nurse #10 on 3/20/25 at 12:54 PM, she revealed that the Midodrine medication was held on 3/4/25. She indicated she must not have coded the MAR correctly. Multiple attempts were made to contact Nurse #3, Nurse #8, and Nurse #11 during the investigation, but they did not return the phone calls. The Director of Nursing (DON) was interviewed on 3/20/25 at 1:14 PM. She revealed that all nurses should not have chosen the code in the MAR that indicated Midodrine was administered for Resident #29 when it was not given. They should have chosen the correct code of "5 - Hold/See Nurses Note." During an interview with the Administrator on 3/20/25 at 1:16 PM, he revealed that all nurses should have chosen "hold" rather than administered when Midodrine was not given in February and March 2025. 2. Resident #7 was admitted to the facility on 10/05/23. Resident #7 had diagnoses which included a pressure ulcer of sacral region stage 3.	F 842	order. The unit manager, MDS Coordinator, and/or the charge nurse will address all concerns identified during the audit to include providing retraining as appropriate. The Director of Nursing will review the Treatment Administration Audit Report for treatments 5 times a week x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will present the findings of the Medication Pass Audits and the Treatment Administration Audit Report to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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The Minimum Data Set (MDS) significant change assessment dated 1/06/25 revealed Resident #7 had moderate cognitive impairment and was coded for a stage 3 pressure ulcer.

Resident #7 had a physician order dated 1/28/25 to validate wound vac (negative pressure wound therapy) function and setting every shift for monitoring.

Observations of Resident #7 were conducted on 3/19/25 at 8:30 am and 9:30 am with the wound vac machine was noted to be in the off position and the drainage canister was empty.

A wound care observation was conducted on 3/19/25 at 10:20 am with the Wound Treatment Nurse. Upon initiation of the treatment, Resident #7's wound vac was noted to connected to the wound vac dressing, the machine was in the off position, and the drainage canister was empty. The Wound Treatment Nurse removed the wound vac therapy and changed the treatment to a wet to dry dressing due to appearance of the wound bed.

Review of Resident #7's Medication Administration Record (MAR) for 3/19/25 through 3/20/25 revealed the following:

3/19/25 7:00 am to 3:00 pm shift- the wound vac was validated as functioning with proper settings by Nurse #2.

3/19/25 3:00 pm to 11:00 pm shift- the wound vac was validated as functioning with proper settings by Nurse #2.

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3/19/25 11:00 pm to 7:00 am shift- the wound vac was validated as functioning with proper settings by Nurse #1.

3/20/25 7:00 am to 3:00 pm shift- the wound vac was validated as functioning with proper settings by Nurse #6.

An attempt to interview Nurse #1 on 3/20/25 at 10:39 am was unsuccessful.

An attempt to interview the Wound Treatment Nurse on 3/20/25 at 10:42 am was unsuccessful.

An interview was conducted on 3/20/25 at 10:48 am with Nurse #2 who revealed she was not notified by the Wound Treatment Nurse on 3/19/25 that Resident #7's wound vac was removed. Nurse #2 stated she did not really look at the wound vac because the Wound Treatment Nurse took care of the wound. Nurse #2 stated she did not recall if she checked if Resident #7's wound vac was functioning and at the correct setting before she documented it was for the 7:00 am-3:00 pm and 3:00 pm-11:00 pm shifts on 3/19/25.

An interview and observation with Nurse #6 was conducted on 3/20/25 at 10:51 am. Nurse #6 stated she did not perform wound treatments at the facility but confirmed Resident #7 no longer had the wound vac therapy in place. Nurse #6 stated the Wound Treatment Nurse had just completed Resident #7's wound treatment and she did not report that the wound vac therapy was removed and the order was still in the computer. Nurse #6 was unable to state why she documented Resident #7's wound vac therapy to be functioning with correct settings without

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F 842	Continued From page 29 confirming it was in place. During an interview on 3/20/25 at 11:02 am the Director of Nursing (DON) revealed the nurses were responsible for checking the wound vac prior to documenting it was functioning. She stated the nurses should not have documented the wound vac therapy was functioning when it was no longer in place. The DON stated the Wound Treatment Nurse should have discontinued or placed the wound vac therapy orders on hold so the staff would know what treatment was being performed.	F 842		
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. §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;	F 880		4/17/25

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F 880	Continued From page 30 §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 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.	F 880		

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F 880	Continued From page 31 §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 implement their infection prevention program policies and procedures when the Wound Treatment Nurse failed to apply personal protective equipment (PPE) during wound care for residents on Enhanced Barrier Precautions (EBP). This deficient practice was for for 1 of 1 staff member observed for wound care (Wound Treatment Nurse). The findings included: The facility's Infection Prevention and Control Program (IPCP) policy last updated 4/2023 indicated that the facility was responsible for establishing and maintaining an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. The policy further noted that the objectives of the IPCP included ensuring proper utilization of standard precautions and or when needed, transmission-based precautions which should be the least restrictive possible for a resident under the given circumstances. The facility's Enhanced Barrier Precautions (EBP) policy last revised 7/26/22 revealed EBP was to be utilized for all residents who had a wound (skin opening that required a dressing). The policy further noted that personal protective equipment (PPE) for EBP was necessary when performing high-contact care activities which included wound	F 880	F 880 Infection Prevention & Control On 3/19/2025, the Treatment Nurse was educated by Director of Nursing (DON) regarding Enhanced Barrier Precautions with emphasis on applying appropriate personal protective equipment (PPE) for all residents requiring Enhanced Barrier Precautions (EBP). The Treatment Nurse also completed a successful return demonstration utilizing PPE prior to providing care to Resident #7 that required Enhanced Barrier Precautions. On 4/11/25 the Director of Nursing (DON) initiated 10 random audits of nurses and/or nursing assistants. This audit is to identify any additional concerns regarding infection control/enhance barrier precautions. The DON will address all concerns identified during the audit to include training of staff. Random audits will be completed by 4/17/25. Beginning 4/17/2025, the Infection Preventionist will increase rounds in the facility to ensure compliance with infection control policies including Enhanced Barrier Precautions. On 4/1/2025, the Director of Nursing (DON) initiated an in-service for all nurses and nursing assistants regarding Infection Control/Enhance Barrier Precautions with	

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F 880	Continued From page 32 care and required staff to wear gloves and gown when the wound care was provided. a. Resident #7 had signage posted on the door that alerted staff that the resident was on EBP. The signage noted that providers and staff must wear gloves and gowns for the following high-contact resident care activities which included wound care. A 3-drawer bin was observed in the hall stocked with PPE, which included disposable gowns. A continuous observation of wound care was conducted on 3/19/25 at 10:20 am through 10:45 am for Resident #7. The Wound Treatment Nurse was observed to perform hand hygiene and don clean gloves and began to perform wound care for Resident #7. The Wound Treatment Nurse performed Resident #7's stage 3 sacral pressure ulcer treatment without a gown in place. During an interview on 3/29/25 at 11:38 am the Wound Treatment Nurse confirmed Resident #7 was on EBP for her wounds and she was required to wear a gown during the wound care. The Wound Treatment Nurse stated she normally wore a gown when she performed wound care but she must have forgotten to put on a gown when she performed Resident #7's wound treatment. An interview was conducted with the Director of Nursing (DON) on 3/19/25 at 2:35 pm who revealed the facility did not have an Infection Preventionist but she stated she had worked with the previous Unit Manager to provide education to staff regarding EBP and use of PPE. The DON stated the Wound Treatment Nurse was required	F 880	emphasis on the appropriate use of personal protective equipment (PPE) for all residents requiring Enhanced Barrier Precautions (EBP) to include but not limited to residents with wounds. The in-service will be completed by 4/17/2025. Any nurse or nursing assistant that has not received the in-service by 4/17/2025 will receive the in-service by the unit manager or DON prior to the next scheduled shift. All newly hired nurses and nursing assistants will receive the in-service on Infection Control/Enhanced Barrier Precautions during orientation by the DON. The Unit Manager, Charge Nurse, and/or the DON will conduct 5 observations of nurses or nursing assistants weekly x 4 weeks then monthly x 1 month utilizing the Infection Control Audit Tool. This audit is to ensure staff utilize appropriate PPE for isolation indicated to include enhance barrier precautions. Any concerns identified during the audit will be immediately addressed by the unit manager, charge nurse, and/or the DON to include providing additional staff training. The DON will review the Infection Control Audit tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing (DON) or Administrator will forward the results of the Infection Control PPE Audit tool Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI committee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345513	A. BUILDING _____ B. WING _____	C 03/20/2025

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F 880	Continued From page 33 to wear a gown when she performed wound care for Resident #7. During an interview on 3/20/25 at 1:40 pm with the Administrator he revealed the Wound Treatment Nurse should have followed the guidelines for EBP when she performed wound care. b. Resident #22 had signage posted on the door that alerted staff that the resident was on EBP. The signage noted that providers and staff must wear gloves and gowns for the following high-contact resident care activities which included wound care. A 3-drawer bin was observed in the hall stocked with PPE, which included disposable gowns. A continuous observation was conducted on 3/19/25 at 11:07 am through 11:37 am for Resident #22's wound care treatment. The Wound Treatment Nurse was observed to perform hand hygiene and don clean gloves and began wound care for Resident #22. The Wound Treatment Nurse completed Resident #22's stage 3 pressure ulcer and venous stasis ulcer (wound on the leg or ankle caused by abnormal or damage to veins) treatments to the lower extremities without a gown in place. During an interview on 3/29/25 at 11:38 am the Wound Treatment Nurse confirmed Resident #22 was on EBP for his wounds and she was required to wear a gown during the wound care. The Wound Treatment Nurse stated she normally wore a gown when she performed wound care but she must have forgotten to put on a gown when she performed Resident #22's wound treatments.	F 880	meet monthly for 2 months to review the Infection Control PPE Audit tools for trends and/ or issues and to determine the continued need and frequency of monitoring.	

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F 880	Continued From page 34 An interview was conducted with the Director of Nursing (DON) on 3/19/25 at 2:35 pm who revealed the facility did not have an Infection Preventionist but she stated she had worked with the previous Unit Manager to provide education to staff regarding EBP and use of PPE. The DON stated the Wound Treatment Nurse was required to wear a gown when she performed wound care for Resident #22. During an interview on 3/20/25 at 1:40 pm with the Administrator he revealed the Wound Treatment Nurse should have followed the guidelines for EBP when she performed wound care.	F 880		