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	345193	A. BUILDING _____ B. WING _____	C 04/17/2025

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MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 04/14/25 through 04/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: VZN211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/14/25 through 04/17/25. Event ID: VZN211. The following intakes were investigated: NC00226094, NC00223710, NC00223779, NC00223542, NC00221366, and NC00215809. 5 of 6 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		5/25/25

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

Electronically Signed | 05/11/2025

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to treat a resident in a dignified and respectful manner when Nurse Aide #1 raised her voice, yelled and argued with a resident causing the resident to become upset for 1 of 3 residents reviewed for dignity (Resident #122). A reasonable person would not want to be yelled at and could feel belittled, scared or threatened when spoken to in such an undignified manner. Findings included: Resident #122 was admitted to the facility on 02/27/24. The quarterly Minimum Data Set (MDS) assessment dated 09/05/24 revealed Resident	F 550	Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement by Mountain View Manor of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law. 1.The resident #122 was discharged on 11/28/24 to the VA and then transitioned to the VA nursing home. Education was	

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F 550	Continued From page 2 #122 had moderate impairment in cognition. He had no behaviors and required assistance with toileting hygiene and transfers. Review of the facility's investigation documentation revealed on 08/28/24, Nurse #2 and Nurse Aide (NA) #2 reported they witnessed NA #1 display verbal aggression toward Resident #122 by yelling and arguing with him after he had fallen while attempting to go to the bathroom unassisted. When NA #2 continued arguing back and forth with Resident #122, Nurse #2 intervened and removed NA #1 from the room. Corrective actions included mandatory inservice for all staff on residents rights, neglect, abuse and exploitation. In addition, NA #1 was immediately suspended and her employment subsequently terminated on 09/02/24 following the completion of the facility's investigation. Resident #122 discharged from the facility on 11/26/24 and was unable to be interviewed. An undated witness statement written by NA #1 revealed in part that on 08/28/24 after Resident #122 had fallen in the bathroom she asked him why he had attempted to go to the bathroom unassisted and Resident #122 started shouting at NA #1 stating that was what she told him to do. NA #1 noted in the statement that she denied telling that to Resident #122 and "in an attempt to defend myself, I did raise my voice." NA #1 further noted in the statement, "I admit I shouldn't have spoken loudly to any resident, I feel that it could have been handled better by all parties involved." During a phone interview on 04/16/25 at 4:54 PM, NA #1 recalled on the evening of 08/28/24, NA #2	F 550	completed with all staff at the time of the incident. 2. Resident rights were reviewed by the Administrator and Administrator-in-Training on 5/9/2025 at the ad-hoc Resident Council meeting. Administrator-in-Training and the Director of Social Services audited all residents on 5/9/25 about their rights as residents of our facility. No other instances were reported. 3.All staff will be re-educated by the assigned course in Relias on Resident Rights and Dignity. All staff will have the assigned task completed by 5/23/25. This course in Relias is also assigned upon hire to all new team members. All dept leaders were educated on 5/9/25 on Embrace Rounds and the rounds will be implemented on 5/12/25. Embrace rounds ensure residents are connected with a leader; this relationship allows for them to give feedback and concerns in real time. The Administrator and the Administrator-in-Training will oversee this weekly process. Any concerns communicated will be addressed in real time using the grievance process. 4.The Administrator will be responsible for reporting monthly in the QAPI meeting on the progress of Embrace Rounds. Any deficient practice will be corrected via the QAPI process. Completion Date 5/25/2025	

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F 550	Continued From page 3	F 550		

called her to the room because Resident #122 had fallen on the bathroom floor and the door wouldn't open. NA #1 stated she managed to wedge herself through the door to get it open for Nurse #2 and NA #2 to come in. When Nurse #2 asked Resident #122 what happened, Resident #122 started yelling and screaming at her (NA #1) stating that she had told him to go to the bathroom. NA #1 stated she responded by telling Resident #122 that what he was saying was not true and she never told him to take himself to the bathroom. NA #1 stated she never cursed or yelled at Resident #122 but did disagree with what he was telling Nurse #2. NA #1 stated she was asked to leave the room by Nurse #1, was sent home that night and a few days later she was notified her employment was terminated.

During a phone interview on 04/16/25 at 4:28 PM, Nurse #2 confirmed she had worked at the facility on 08/28/24 during the hours of 7:00 PM to 7:00 AM and recalled being notified that Resident #122 had fallen on the bathroom floor. Nurse #2 stated she couldn't recall the exact specifics of what happened but did remember as she entered Resident #122's bathroom, NA #1 came in behind her and stood over Resident #122 with one leg on each side of him. Nurse #2 stated when she asked Resident #122 what happened, he looked at NA #1 and stated he only did what she (NA #1) told him to do, which was to "get up off his butt and go to the bathroom." Nurse #2 recalled NA #1 then started screaming and cursing stating she never said anything like that to Resident #122. Nurse #2 stated Resident #122 was upset, so she intervened instructing NA #1 to leave the room and called the Nurse Supervisor to let her know what had happened. Nurse #2 stated after NA #1 left the room and staff assisted Resident

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F 550	Continued From page 4	F 550		

#122 up off the floor and back to bed, he calmed down and returned back to his baseline.

During a phone interview on 04/17/25 at 9:48 AM, NA #2 revealed she witnessed the incident involving Resident #122 and NA #1 on 08/28/24. NA #2 stated at the time, she was a Personal Care Assistant (PCA) and was going room-to-room with NA #1 helping with what she could. NA #2 recalled early in the shift on 08/28/24 around 5:00 PM, she went into Resident #122's room with NA #1 because he had wet the bed. She recalled Resident #122 had recently returned from the hospital and wasn't feeling well. NA #2 stated NA #1 started getting "snippy" (irritable) with Resident #122 and asking him various questions such why he hadn't used the urinal like he used to and why he didn't just get up and go to the bathroom. NA #2 couldn't recall the exact time but stated it was sometime later in the shift when she had checked in on Resident #122 and found him lying on the bathroom floor and called for NA #1 to come to the room. NA #2 stated she and Nurse #2 were both present when NA #1 raised her voice when asking Resident #122 why he was in the bathroom. NA #2 stated when Resident #122 told NA #1 that he was just doing what she had told him to do, NA #1 started yelling at Resident #122 stating she never told him to do that. NA #2 stated Resident #122 was upset that he had fallen and NA #1 talking and arguing with him the way she did just upset him further. NA #2 stated NA #1 never cursed at Resident #122 but she was being very disrespectful and argumentative toward Resident #122.

During an interview on 04/17/25 at 3:22 PM, the Administrator revealed it was never appropriate

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F 550	Continued From page 5 for staff to speak to residents disrespectfully. He explained if residents were resistive or upset, staff were instructed to walk away from the situation and get another staff member to try and provide the resident's care. The Administrator explained at the time of the incident with Resident #122, NA #1 was going through a lot of personal issues which he felt likely contributed to her losing control of her behavior and speaking disrespectfully to Resident #122 but it should have never escalated to the point that it did. The Administrator stated he did not feel that NA #1 was verbally abusive to Resident #122 but she was definitely disrespectful, which was never acceptable.	F 550		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to protect resident rights to be free from misappropriation of controlled medication for 1 of 7 residents reviewed for misappropriation of resident property (Resident #276). The findings included: Review of the facilities Abuse, Neglect and	F 602	1.On 10/29/24 Nurse #6 was terminated and reported to the North Carolina Board of Nursing. 2.A complete reconcilliation of medication and medication records was conducted on Thursday, May 8, 2025 by the Pharmacist consultant with Neil Medical Pharmacy. No further instances were found. 3.The Director of Nursing Services provided education regarding narcotic	5/15/25

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F 602	Continued From page 6 Exploitation policy and procedure which was last reviewed on 4/4/25 revealed that the facility stated residents had the right to be free from misappropriation of property. Resident #276 was admitted to the facility on 1/13/23 with diagnosis that included depression, anxiety disorder and dementia. Review of the quarterly minimum data set (MDS) dated 8/27/24 revealed that Resident #276 was severely cognitively impaired. Review of the physician's order dated 10/16/24 revealed Resident #276 had an order to receive 0.5 milligrams (MG) of lorazepam (a medication used to treat anxiety) every 6 hours as needed for anxiety for 14 Days. Review of the facilities investigation dated 10/26/24 revealed at 9:00 PM on 10/25/45 the Administrator in Training (AIT) was comforting Resident #275. Upon leaving the resident's room the AIT discovered 2 white pills. The AIT took the lorazepam pills to the nurse on the hall Nurse #6. At around 10:00 PM to 10:15 PM the AIT asked Nurse #6 if she had solved the issue with the pills found in Resident #275's room. Nurse #6 stated she was going to waste the pills with another nurse, Nurse #3. Nurse #6 then confirmed the medication did not belong to Resident #275. At 10:15 PM on 10/25/24 Nurse #3 was asked to count narcotics with Nurse #6. The count was completed and there were two narcotics that needed to be fixed/ corrected. The pills were punched out and Nurse #6 stated that she was going to take the pills to the resident that needed them. At 4:50 AM Nurse #7 was reviewing the narcotic count sheet. Nurse #7 found that a	F 602	management and weekly medication reconcilliation to all nursing team members. An in-service will be conducted on 5/14/2025. The medication reconcilliation process will be included in orientation for new nurse hires.A weekly medication reconcilliation process (eMar to cart audit) has been initiated and will be completed by the night shift nursing team; the Director of Nursing Services will be responsible for the oversight of this weekly process. Any deficiencies will be corrected at time of findings. In addition, weekly audits of the narcotic inventory logs and shift count sheets will be completed by the Director of Nursing Services or designee for 4 weeks, any deficient practices will be investigated and corrected. 4.The Director of Nursing Services will bring medication reconcilliation audit results to the QAPI monthly meeting. In addition the weekly match back results will be reviewed in the monthly QAPI meeting. The Administrator will review the weekly audits to ensure compliance of the process. Completion date 5/15/2025	

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controlled medication was marked as wasted and another medication was signed out, but no one was documented as having witnessed the waste. Nurse #7 reached out to Nurse #6 who was still in the building catching up on charting from her shift. Nurse #7 had noted suspicious activity for Resident #276 controlled medication. Nurse #7 then informed the AIT of the suspicious activity. At 5:00 AM on 10/26/24 Nurse #3 was asked to sign for 2 pills that were wasted by Nurse #6. Nurse #3 signed off on the narcotic sheet that the 2 white pills were wasted. The AIT then suspended Nurse #6 pending an investigation. The facility then interviewed Nurse #3, Nurse #6, and Nurse #7 and sent Nurse #6 for a drug test on 10/28/24. Resident # 276's medication administration record (MAR) was reviewed, and it was documented that the controlled medication was as needed and last administered in August 2024. The allegation of diversion of residents' drugs was substantiated and Nurse #6 was terminated on 10/29/24. The facility filed a report to the North Carolina Board of Nursing (NC BON) on 10/29/24. The investigation was documented by the AIT.

Review of the controlled medication count sheet revealed that Nurse #6 had signed out one tablet of lorazepam 0.5 MG for Resident #276 on 10/25/24 at 9:00 PM and then documented it as a wasted punch and another tablet of lorazepam at 9:00 PM and then documented it as a wasted punch. Nurse #3 signed off as having witnessed the wasting of both tablets of lorazepam.

Review of Resident #276's October 2024 Medication Administration Record (MAR) revealed the prn lorazepam was not initialed administered.

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A phone interview with Nurse #3 was attempted several times without success. This Nurse no longer worked at the facility.

A phone interview with Nurse #6 was attempted several times without success. This Nurse no longer worked at the facility.

A phone interview with Nurse #7 was attempted several times without success. This Nurse no longer worked at the facility.

An interview with the AIT on 4/17/25 at 10:24 AM revealed she arrived at the facility at 9:00 PM on 10/25/24 to sit and meet with Resident #275. She sat with Resident #275 for 45 minutes to an hour. She got up and spoke to Nurse #6 to tell her she calmed Resident #275 down. She went back into Resident #275's room and found a little white pill with EP904 on it in his bed. She took the pill to Nurse #6, and Nurse #6 snatched it out of the AIT's hand and placed it in a little plastic medication cup and placed that in the top drawer of Nurse #6's medication cart. The AIT stated that she went back into Resident #275's room and saw a second little white pill with EP904 on it on the ground next to Resident #275's shoe. She took that second pill to Nurse #6 and asked her what it was. She stated that Nurse #6 told the AIT she wasn't supposed to see that and took the pill from her. Nurse #6 then stated that she would waste the medication after she finished her medication pass. The AIT stated that she googled EP904 and discovered the medication was lorazepam. She stated that when Nurse #7 came in between 10:00 PM to 10:30 PM the AIT asked Nurse #7 to verify if Resident #275 had an order for lorazepam. Nurse #7 informed the AIT that

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Resident #275 did not have an order for lorazepam. Nurse #7 looked at the controlled medication count sheet for Resident #275 and stated that the documentation was incomplete and asked if Nurse #6 was still at the facility. The AIT told Nurse #7 that Nurse #6 was still there. Nurse #7 stated that she was going to go take care of it with Nurse #6. The AIT stated that Nurse #7 confronted Nurse #6 about correcting the controlled medication count sheet. She stated that Nurse #7 said Nurse #6 had first asked her to sign the witness section for the two wasted lorazepam tablets. Nurse #7 stated that she had refused as she was not present during the wasting of the lorazepam. The AIT explained Nurse #6 then took the controlled medication count sheet to Nurse #3 and asked her to sign the witness for the lorazepam waste that Nurse #6 stated she had completed earlier in the night. Nurse #3 signed off the witness signature for the 2 lorazepam tablets Nurse #6 stated she had wasted. The AIT the called the Administrator and the former Director of Nursing (DON) immediately. The AIT stated that she then asked Nurse #3 if she had witnessed Nurse #6 wasting the 2 lorazepam tablets earlier. Nurse #3 stated no she didn't see the pills get wasted and she knew she shouldn't have signed off on the controlled medication count sheet. The AIT revealed that Nurse #6 had already left at this point and the former DON called Nurse #6 to let her know she was suspended pending an investigation. On Monday 10/28/24 she sent Nurse #6 to get a drug test, and they terminated Nurse #6 on 10/29/24 after their investigation was completed.

A phone interview with the former Director of Nursing (DON) on 4/17/25 at 2:03 PM revealed

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F 602	Continued From page 10 that the AIT informed her that she had found lorazepam in Resident #275's room and gave it to Nurse #6. She stated that she was partially involved in the investigation, and she had confirmed that Resident #276 had the orders for the lorazepam. She and the AIT called Nurse #6 together to interview her during the facilities investigation and asked her to take a drug test on 10/28/24. An interview with the Administrator on 4/17/25 at 2:58 PM revealed that 2 of Resident #276's lorazepam pills were found in Resident #275's room on his bed and on the floor beside his shoe and Resident #275 did not have an order for lorazepam. He stated that the facility opened an investigation, reported Nurse #6 to the Board of Nursing, and suspended Nurse #6. He stated that ultimately, they ended up terminating Nurse #6. He indicated that was all the information he had about that investigation.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the	F 607		5/12/25

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F 607	Continued From page 11 QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not maintaining evidence of an investigation into misappropriation of property and not immediately reporting an allegation of abuse to the Administrator/designee and not notifying local law enforcement or Adult Protective Services of allegations of abuse or misappropriation of property for 3 of 5 abuse investigations reviewed (Residents #12, #24, #27, #43, #223, #222). The findings included: Review of the facilities Abuse, Neglect and Exploitation policy and procedure which was last reviewed on 4/4/25. The administrator will be immediately notified by staff if abuse, neglect, mistreatment, misappropriation and or exploitation is alleged or suspected. Staff will document the investigation findings including any recommendations of corrective action and such	F 607	1.Nurse #8 is no longer employed by the facility. Resident rights were reviewed by the Administrator, Administrator-in-Training, and Director of Social Services on 5/9/25 at the ad-hoc Resident Council meeting. 2.All residents have potential to be affected. Administrator-in-Training and the Director of Social Services audited all residents on 5/9/25 about their rights as residents of our facility. No other instances were reported. 3.All dept leaders were educated on 5/7/25 on Embrace Rounds and the daily Embrace rounds began on 5/9/25. Embrace rounds ensure residents are connected with a leader; this relationship gives them the opportunity to give feedback and express concerns in real time. The Administrator and the Administrator-in-Training will oversee this process. Any concerns communicated will	

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F 607	Continued From page 12 documentation will be retained as part of the investigation file. a. Review of the initial allegation report submitted by the facility to the State Agency noted an allegation type of misappropriation of resident property that the facility was made aware of on 4/12/24 at 4:52 PM that noted the medications of Resident #12, Resident #24, Resident #27, and Resident #43 were found in Nurse #8's personal bag at the nurse's station. The facility attempted to notify Nurse #8 of her suspension and local law enforcement were notified of misappropriation of resident property. A review of the facility's investigation documentation revealed that Nurse #8 had removed the medications from the cart because the residents no longer used the medications or they were expired. The investigation consisted of a statement from Nurse #8 and interviews conducted with alert and oriented residents asking if they were happy with their care, if staff was treating them with dignity and respect, and if the nurses provided care including medications in a professional manner. There was no additional information included in the facility's investigation such as the names of the medications or amount of medications for each resident that was found in Nurse #8's personal bag. Several attempts were made to interview Nuse #8 with no success. She no longer worked at the facility. A phone interview with the former Director of Nursing (DON) on 4/17/25 at 2:03 PM revealed that she had been the DON for approximately 2 months when this incident occurred. She stated	F 607	be addressed in real time using the grievance process. Embrace rounds will be included in new hire orientation. The Administrator, Administrator-in-Training, and Director of Nursing Services were educated by the Director of Clinical Operations on 5/9/25 to ensure understanding of the Investigation and Event Reporting process; the training was conducted by Director of Clinical Operations. Any future investigations will be reviewed by the Regional Vice President or designee to ensure compliance. 4.All investigations will be reviewed as part of the QAPI process by the interdisciplinary team which includes the Administrator, Administrator-in-Training, Director of Nursing Services, Director of Social Services, and other administrative team members. Completion Date 05/12/2025	

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that she saw a bag at the nursing station and when she checked the bag, there were resident medications inside. She stated that she started the initial report to submit to the State Agency and notified the Social Worker, Administrator and Corporate. The former DON explained as part of the investigation, she got a statement from Nurse #8, notified the physician, monitored the residents for adverse reactions, got a list of medications that were found, and initiated a plan of correction. In addition, she obtained drug screen from Nurse #8, notified local authorities, notified the resident's responsible parties and or the residents. She stated that she had completed a thorough investigation and was unsure why none of the documentation for all the things she completed was gone.

An interview with the Administrator on 4/17/25 at 3:01 PM revealed that the former DON stated that some staff brought the bag with the resident medications in them to her. He stated that the investigation was a reportable to the State Agency and there was an attempt to interview Nurse #8. He stated that he was uncertain of what steps were completed as part of this investigation and had no idea where the missing documentation for the investigation might be.

A phone interview with the former Corporate Nurse on 4/17/25 at 3:41 PM revealed that as part of the investigation, all she did was ask the alert and oriented residents about their care and medication administration and no residents had reported any issues. She stated that she was normally the one who returned medications to pharmacy for destruction but she could not recall if she returned the medications that were found in Nurse #8's bag. The Corporate Nurse stated she

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was unsure where any additional documentation related to the investigation would be located.

b. Review of the initial allegation report submitted by the facility to Division of Health Service Regulation (DHSR) via fax transmission on 11/01/24 at 5:40 PM noted an allegation of diversion of resident drugs that the facility was made aware of on 11/01/24 3:30 PM. It was alleged that a possible diversion of medication had occurred due to Resident #223's liquid Morphine being an abnormal color. The allegation was not reported to law enforcement.

Review of the 5-day investigative report submitted by the facility to DHSR via fax transmission on 11/06/24 at 9:25 AM noted Adult Protective Services (APS) was not notified of the allegation. Further review revealed the allegation of diversion of resident drugs was unsubstantiated.

An interview with the Social Worker (SW) on 04/15/25 at 3:02 PM revealed she completed the 24-hour/5-day report for the allegation of possible diversion of Resident #223's liquid Morphine. She stated she did not notify law enforcement or APS because she wasn't instructed to by the Administrator. The SW stated the Director of Nursing (DON) and Administrator were also involved in the investigation and she only completed the reports and faxed them to DHSR.

A telephone interview with the former DON on 04/15/25 at 4:37 PM revealed she completed interviews with nurses working on Resident #223's hall when the liquid Morphine was noted to be clear in color instead of blue and sent the Morphine back to the pharmacy. She stated that

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was all she could recall regarding the allegation and the SW and Administrator would probably have more information.

An interview with the Administrator on 04/16/25 at 2:04 PM revealed the SW completed the 24-hour report and the department involved with the allegation completed the 5-day investigation. He stated once the information was collected for the 24-hour/5-day reports, he reviewed the information and consulted with the former Compliance Officer to see if any additional actions should be taken, and if not the report was sent to DHSR. The Administrator stated the former Compliance Officer did not instruct him to notify law enforcement or APS.

c. Review of the initial allegation report submitted by the facility to Division of Health Service Regulation (DHSR) via fax transmission on 01/11/25 at 4:48 PM noted an allegation type of resident abuse that the facility was made aware of on 01/11/25 at 8:30 AM. Nurse #3 alleged that Nurse #4 was unable to focus when caring for Resident #222 the night of 12/14/24, went to his car for long periods of time and was sleepy when he returned, drew up liquid Morphine for Resident #222 and placed the syringe behind his ear and had to be told to administer the medication, and gave the liquid Morphine too rapidly, causing the resident to get strangled. Law enforcement was not notified of the allegation.

Review of the 5-day investigative report submitted by the facility to DHSR via fax transmission on 01/14/25 at 12:33 PM noted Adult Protective Services (APS) was not notified of the allegation on 01/11/25. Further review revealed the allegation of resident abuse was unsubstantiated.

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Nurse #3 and Nurse #4 were unavailable for interview during the investigation.

An interview with the Social Worker (SW) on 04/15/25 at 3:02 PM revealed she was unsure if the allegation for Resident #222 needed to be reported to DHSR and did not complete the 24-hour/5-day report until she was instructed to by the Administrator. She further stated she did not notify law enforcement or APS because she wasn't instructed to by the Administrator. The SW stated the Director of Nursing (DON) and Administrator were also involved in the investigation and she only completed the reports and faxed them to DHSR.

A telephone interview with the former DON on 04/15/25 at 4:37 PM revealed she could not recall any further details about the allegation of resident neglect for Resident #222 and the SW and Administrator would have more information about the allegation.

An interview with the Administrator on 04/16/25 at 2:04 PM revealed he was unsure why Nurse #3 waited so long to report the allegation of abuse for Resident #222 since she had received education multiple times on immediately reporting abuse or neglect concerns to him or the SW. He was unable to explain why the initial report was not submitted within the 2-hour time frame. The Administrator explained the SW completed the 24-hour report and the department involved with the allegation completed the 5-day investigation. He stated once the information was collected for the 24-hour/5-day reports, he reviewed the information and consulted with the former Compliance Officer to see if any additional

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F 607	Continued From page 17 actions should be taken, and if not the report was sent to DHSR. The Administrator stated the former Compliance Officer did not instruct him to notify law enforcement or APS.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of oxygen use for 1 of 3 residents reviewed for respiratory care (Resident #272). The findings included: Resident #272 was admitted to the facility on 04/12/25 with diagnoses that included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues). A review of Resident #272's physician orders revealed an order dated 04/13/25 for oxygen to be administered continuously via nasal cannula at 3 liters per minute, may titrate to keep oxygen (O2) saturation greater than 90%. A review of the admission Minimum Data Set dated 04/12/25 revealed Resident #272 was not coded for oxygen use. An observation on 04/14/25 at 11:56 AM revealed	F 641	1.On 4/18/2025 for resident #272 the MDS was modified to code oxygen currently. 2.All residents have the potential to be affected. An audit of 100% of MDSs for current residents to ensure accurate coding of oxygen use will be completed by the MDS nurse by 5/23/25. For any inaccuracy found, the MDS coding of oxygen use will be corrected at this time. 3.Registered Nurse Assessment Coordinator will have second person (DCR or designee) to review assessments including oxygen use prior to completion and submission of the record. Education was provided by the Director of Clinical Reimbursement to Registered Nurse Assessment Coordinators on 5/7/25 for coding oxygen use on MDS. Correct coding of oxygen use will be included in orientation for new hires for the MDS position. 4.Administrator/ Director of Nursing Services/designee will audit 100% of MDS completed each week for 4 weeks then sample audits monthly for 2 months - to	5/24/25

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F 641	Continued From page 18 Resident #272 sitting in his wheelchair by his bed with oxygen being administered via nasal cannula by an oxygen concentrator.	F 641	identify any inaccuracy in oxygen use coding. Findings of this audit will be reviewed in QAPI monthly where extensions to plan will be made based on center compliance. Completion date 05/24/2025	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		5/18/25

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F 655	Continued From page 19 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of a resident's admission (Resident #272) and ensure a baseline care plan addressed insulin use for a resident with diabetes (Resident #73) for 2 of 4 residents reviewed for respiratory care and self-administration of medications. The findings included: 1. Resident #272 was admitted to the facility on 04/12/25 with diagnoses that included chronic respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues). A review of Resident #272's medical record revealed no baseline care plan had been developed for him within 48 hours of admission. On 04/17/25 at 9:16 AM an interview with the Admission/Discharge Nurse revealed she was responsible for completing baseline care plans,	F 655	1.For resident #272- A Complete Baseline care plan was completed by Registered Nurse Assessment Coordinator on 4/18/2025. For resident #73- A Complete baseline care plan addressing insulin was not completed. Resident #73 discharged 5/10/2025. 2.All residents have the potential to be affected. An admission/readmission review (via the admission checklist) will be conducted on each resident during Clinical Start up to by the Health Information Management Coordinator or Director of Nursing Services to ensure that 100% of Baseline care plans are completed within 48 hours. Any deficiencies noted will be corrected at that time. 3.The Director of Nursing Services educated all nurses on the Baseline care plan completion to ensure the needs, preferences and routines of each resident are addressed, all nurses will have completed the education by 5/17/2025.	

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F 655	Continued From page 20 but if a resident was admitted over the weekend the nurse on the hall admitting the resident was responsible for completing it. An interview on 04/17/25 at 10:14 AM with the MDS Coordinator revealed the nurse on the hall who admitted a resident was responsible for completing the baseline care plan. An observation of Resident # 272's electronic medical record with the MDS Coordinator showed no baseline care plan. An interview on 04/17/25 at 12:32 PM with the Director of Nursing (DON) revealed the facility computers were not working over the past weekend as the facility had been acquired by another company and the computers were being changed over. She indicated the admitting nurse was responsible for completing the baseline care plan, and that it was important for a baseline care plan to be completed for resident care needs and preferences to be known. On 04/17/25 at 3:38 PM an interview with the Administrator revealed baseline care plans should be completed timely and accurately by the admitting nurse. 2. Resident #73 was admitted to the facility 04/07/25 with a diagnosis including diabetes. Review of Resident #73's Physician orders revealed orders dated 04/07/25 for Insulin Glargine 100 units per milliliter inject 30 units subcutaneously (under the skin) at bedtime and Insulin Lispro 100 units per milliliter per sliding scale before meals and at bedtime. A review of Resident #73's baseline care plan	F 655	On 5/7/25 education was provided by the Director of Clinical Reimbursement to the Registered Nurse Assessment Coordinator regarding care plan review. The IDT team including Director of Nursing Services, Assistant Director of Nursing Services, MDS/ Registered Nurse Assessment Coordinator will review care plans weekly per schedule to ensure care plan reflects resident centered care. Any deficiencies will be corrected immediately. Baseline care plan completion will be included in orientation for newly hired nurses. 4.The Administrator, Director of Nursing Services, or designee will audit 100% of Baseline care plans completed each week for 4 weeks then sample audits monthly for 2 months - to identify any deficiency in resident centered care. Findings of this audit will be reviewed in QAPI monthly where extensions to plan will be made based on center compliance. Completion date 05/18/2025	

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F 655	Continued From page 21 dated 04/08/25 revealed in the "Medications/Treatments" there was no indication she received Insulin and in the "Medical Conditions" section there was no indication she had a diagnosis of diabetes. Review of the admission Minimum Data Set (MDS) assessment dated 04/14/25 revealed it was "in progress". In an interview with the Admission/Discharge Nurse on 04/17/25 at 9:15 AM she confirmed she completed Resident #73's baseline care plan. She stated Resident #73's baseline care plan should have reflected that she had a diagnosis of diabetes and received Insulin, and it was overlooked. An interview with the Director of Nursing (DON) on 04/17/25 at 2:02 PM revealed she expected a baseline care plan to accurately reflect a resident's diagnosis and medications. She stated Resident #73's baseline care plan should have reflected she was a diabetic and received Insulin and, the person completing the baseline care plan was responsible for ensuring it was accurate. An interview with the Administrator on 04/17/25 at 3:32 PM revealed he expected baseline care plans to be accurate.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		5/24/25

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F 677	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide showers as scheduled to a resident dependent on staff assistance for bathing for 1 of 4 residents reviewed for activities of daily living (Resident #2). Findings included: Resident #2 was admitted to the facility on 07/26/23 with diagnoses that included chronic obstructive pulmonary disease (trouble breathing), heart failure, and anxiety disorder. The quarterly Minimum Data Set (MDS) dated 03/11/25 assessed Resident #2 with intact cognition and was dependent on staff assistance with showering/bathing and transfers. She displayed no behaviors and did not reject care during the MDS assessment period. A review of Resident #2's comprehensive care plans last reviewed/revised on 03/13/25 revealed she had an activities of daily living self-care performance deficit related to deconditioning, COPD and heart failure. Interventions included dependence on staff with showering twice weekly and as necessary. Review of the master shower schedule revealed Resident #2 was scheduled to receive a shower on Wednesday and Saturday during the hours of 7:00 AM to 3:00 PM. Review of the Nurse Aide (NA) point of care documentation report for April 2025 revealed no evidence Resident #2 received her showers on	F 677	1.Resident # 2 was discharged to a nursing home in Waynesville on 4/28/25. 2.All residents have the potential to be affected. An audit of all residents was completed on 5/6/25 by the MDS nurse to ensure that all residents requiring assistance with showers have appropriate care plan task assigned, any deficiencies were corrected immediately, and the nurse aide team was informed of updates. 3.The nursing team (nurses and certified nursing assistants) were assigned the Relias course Documentation of Activities of Daily Living to be completed by 5/23/25. New nursing employee orientation will include the Relias course Documentation of Activities of Daily Living. The Director of Nursing Services or designee will audit the residents shower documentation daily for 2 weeks, then weekly for 4 weeks. Any deficiencies will be addressed by the Administrator via the grievance procedure. 4.The ADL audit findings will be reviewed by the IDT during the monthly QAPI meeting, any deficient practice will be corrected. Completion date 05/24/2025	

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F 677	Continued From page 23	F 677		

Saturday as scheduled.

During an observation and interview on 04/14/25 at 3:45 PM, Resident #2 was lying in bed with the head of bed slightly elevated. Resident #2's hair was uncombed and appeared greasy. Resident #2 stated she was supposed to receive two showers per week on Wednesday and Saturday but for the past 3 weeks she had not been receiving her scheduled shower on Saturday. Resident #2 could not recall the name of the staff she spoke with but stated when she asked if she was going to get her shower, their response was "we'll see." Resident #2 revealed staff did not offer to give her a bed bath when a shower wasn't given nor was her hair washed until she received her scheduled shower on Wednesday. Resident #2 expressed when she didn't get a shower, she felt like she smelled and it made her feel "nasty."

During an interview on 04/17/25 at 10:41 AM, Nurse Aide (NA) #3 revealed she was routinely assigned to provide Resident #2's care. NA #3 stated Resident #2 was scheduled to receive showers on Wednesday and Saturday each week and had mentioned to her in the past that she did not always receive her scheduled shower on Saturdays. NA #3 explained she frequently provided Resident #2 her scheduled shower on Wednesdays and she never refused when offered.

NA #4 who provided Resident #2's care on 04/05/25 (Saturday) and NA #5 who provided Resident #2's care on 04/12/25 (Saturday) were unable to be reached for an interview.

During an interview on 04/17/25 at 11:09 AM, the Administrator in Training (AIT) revealed she was

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F 677	Continued From page 24 also a NA and had provided Resident #2 with a shower in the past. The AIT could not recall the date but stated it was one weekend when she was at the facility, Resident #2 had stated she didn't get her scheduled shower that Saturday. The AIT stated she reviewed the NA point of care documentation for April 2025 and confirmed there was no documentation to indicate Resident #2 was provided her showers on Saturdays as scheduled. During an interview on 04/17/25 at 3:22 PM, the Administrator stated he would expect for staff to provided residents their showers as scheduled.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post cautionary and safety signage outside a resident's room that indicated the use of oxygen for 1 of 3 residents reviewed for respiratory care (Resident #272). The findings included: Resident #272 was admitted to the facility on 04/12/25 with diagnoses that included chronic	F 695	1.For resident #272, oxygen signage was placed 4/14/25 on residents door. 2.A 100% audit was completed by the central supply dept on 5/6/25 to ensure that all residents with orders for oxygen had appropriate cautionary signage, and any deficiencies were corrected immediately. 3.On 5/7/25 The Director of Nursing Services provided education to all nurses	5/8/25

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F 695	Continued From page 25 obstructive pulmonary disease and chronic respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues). A review of Resident #272's physician orders revealed an order dated 04/13/25 for oxygen to be administered continuously via nasal cannula at 3 liters per minute, may titrate to keep oxygen (O2) saturation greater than 90%. A review of the admission Minimum Data Set (MDS) dated 04/12/25 indicated Resident #272 exhibited no behavior or rejection of care and was not coded for oxygen use. An observation on 04/14/25 at 11:56 AM revealed Resident #272 sitting in his wheelchair by his bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside his room indicating supplemental oxygen was in use. An observation on 04/15/25 9:22 AM revealed Resident #272 lying in bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside his room indicating supplemental oxygen was in use. An interview with Nurse #1 on 04/16/25 at 3:19 PM revealed the nurse assigned to the hallway was responsible for placing the oxygen in use signage but she was not aware where the signage was kept. On 04/16/25 at 2:12 PM an interview was held with the Director of Nursing (DON). She indicated the nurse who admitted a new resident	F 695	regarding placement of cautionary signage for residents with oxygen. Placement of cautionary signage will be included in new hire orientation for nursing personnel. 4.The Director of Nursing Services or designee will conduct an audit of signage for residents with oxygen, weekly for 4 weeks, to ensure compliance, any deficiencies found will be corrected immediately.The Director of Nursing Services will bring the signage audit findings to the monthly QAPI meeting. The Administrator will review for deficient practices. Any deficiencies noted will be corrected. Completion date 05/08/2025	

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F 695	Continued From page 26 was responsible for placing the oxygen signage on the resident's door, but any nurse could place the signage. The DON continued to voice the oxygen in use signage should have been placed on Resident #272's door and was not certain why it was not in place. An interview with the Administrator on 04/17/25 at 3:38 PM revealed the signage should have been placed on the resident's door and he did not know why it was not in place.	F 695		
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	F 761		5/15/25

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F 761	Continued From page 27 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to secure medications stored at the bedside for 1 of 1 resident reviewed for medication storage (Resident #73). Findings included: Resident #73 was admitted to the facility 04/07/25 with a diagnosis including costochondritis (inflammation of the cartilage that connects a rib to the breastbone). Review of the baseline care plan dated 04/08/25 revealed Resident #73 was cognitively intact. Review of the medical record revealed Resident #73 was assessed for self-administration of medication on 04/08/25. The assessment indicated Resident #73 was not approved for self-administration of medications and may not keep medications at the bedside. Review of Resident #73's Physician orders revealed an order dated 04/09/25 for Diclofenac Sodium gel 1% (anti-inflammatory medication) apply to left chest wall twice a day for 14 days. Resident #73's admission Minimum Data Set (MDS) assessment dated 04/14/25 was "in progress". An observation of Resident #73's room on 04/16/25 at 8:08 AM revealed a tube of Hydrocortisone (anti-inflammatory) cream 1% sitting on top of her overbed table and a	F 761	1.For resident #73, the medication was removed from the room immediately. On 4/16/25 the Director of Nursing Services called the family regarding the medication storage policy to ensure understanding. 2.On 4/18/2025, an audit of all resident rooms was conducted by the Director of Nursing Services to ensure that no other medication storage concerns were noted, and any deficiencies were corrected during the audit. 3.The Director of Nursing Services will educate the nurses on 5/14/25 regarding medication storage procedures. The medication storage policy will be included in new hire orientation for nursing personnel. 4.The Director of Nursing Services will conduct weekly audits for 4 weeks to ensure compliance, any deficiencies will be corrected at that time.The Director of Nursing Services will bring the medication storage audit findings to the monthly QAPI meeting. The Administrator will review for deficient practices. Any deficiencies noted will be corrected. Completion date 05/15/2025	

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medication cup containing a whitish gel-like substance sitting on the dresser beside her bed.

An interview with Resident #73 on 04/16/25 at 8:08 AM revealed the substance in the medication cup was medication provided by the facility that she applied daily to her chest for pain. She stated she was not aware of the name of the substance in the medication cup. Resident #73 further stated her family brought her the Hydrocortisone cream for itchy skin and she applied it when she needed it. She stated she could not recall when she last applied the Hydrocortisone cream.

An interview with the Director of Nursing (DON) on 04/16/25 at 8:17 AM revealed she was unable to identify the whitish substance in the medication cup but stated it should not be left in Resident #73's room.

An interview with Nurse #1 on 04/16/25 at 3:42 PM revealed she was caring for Resident #73 on the 7:00 AM to 7:00 PM shift. She stated she didn't leave the medication cup with the whitish substance on Resident #73's dresser and if she had seen the cup she would have removed it.

An observation of Resident #73's overbed table on 04/17/25 at 8:32 AM revealed a tube of Hydrocortisone cream 1% sitting on top of the table.

A follow-up interview with the DON on 04/17/25 at 2:02 PM revealed the whitish substance in the medication cup on 04/16/25 was most likely Diclofenac Sodium. She stated no medications should be left in a resident's room unless they had been assessed as safe to self-administer the

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F 761	Continued From page 29 medication and if the resident was not safe to administer their medication, the medication should be stored in the medication or treatment cart. An interview with Nurse #5 on 04/17/25 at 3:32 PM revealed she was caring for Resident #73 on the 7:00 AM to 3:00 PM shift. She stated she did not see the Hydrocortisone cream on Resident #73's overbed table and if she had she would have removed it from the room. An interview with the Administrator on 04/17/25 at 3:19 PM revealed he expected staff to store medications appropriately.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		4/21/25

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F 812	Continued From page 30 by: Based on observations and staff interviews, the facility failed to discard expired food from 1 of 1 walk-in cooler, date food items in 1 of 1 walk-in freezer, cover food items in 1 of 1 walk-in cooler, and remove expired food available for use from 1 of 1 dry storage room. This deficient practice had the potential to affect food served to residents. Findings included: 1. An initial observation of the walk-in cooler on 04/14/25 at 10:02 AM revealed a box of thawed premade peanut butter and honey sandwiches with a date of 03/27/25. An interview with the Dietary Manager on 04/14/25 at 10:05 AM revealed the date of 03/27/25 indicated that was the date the sandwiches were placed in the cooler, and she was not sure how long they were good for after they were thawed but she would check. A follow-up interview with the Dietary Manager on 04/16/25 at 11:00 AM revealed she was unable to locate the manufacturer's information on how long the premade sandwiches were good for after being thawed, so she discarded the sandwiches. An interview with the Administrator on 04/17/25 at 3:13 PM revealed he expected food to be stored according to manufacturer's guidelines. 2. An initial observation of the walk-in freezer on 04/14/25 at 10:07 AM revealed 2 undated bags of french toast sitting on a shelf in the freezer and a box of frozen pizzas open to air. An interview with the Dietary Manager on	F 812	1.On 4/17/25 the Dining Services Director did a complete audit of the kitchen and removed all items on non-compliance. 2.All residents have the potential to be affected. All refrigerated foods will be stored, wrapped, or in covered containers, labeled and dated, and arranged for easy identification, and date marked as appropriate, in accordance with the HCSG policy 018 - Food Storage Dry Goods, policy 019 - Food Storage Cold Foods. 3.Proper storage education completed with the Dining Services Director and employees by Food Service Director on 04/15/2025. Proper storage education will be included in new hire orientation for the Dietary department. The Dining Services Director or designee will perform once daily checks utilizing daily MORNING MEETING INSPECTION CHECKLIST to include cooler, refridgerator, freezer, and dry storage, at the beginning of each shift. The checklist will be reviewed by the Administrator to confirm compliance. Any deficient findings will be corrected immediately. 4.The Dining Services Director will present daily audit findings during the monthly QAPI meeting, any deficiencies will be corrected. Completion date 04/21/2025	

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F 812	Continued From page 31 04/14/25 at 10:10 AM revealed the french toast should have had a date written on it when it was placed in the freezer by the staff member. She stated the pizzas should have been covered and not left open to air by the staff member who opened the box. An interview with the Administrator on 04/17/25 at 3:13 PM revealed he expected all food in the walk-in freezer to be dated and covered appropriately. 3. An initial observation of the dry storage room on 04/14/25 at 10:15 AM revealed two and a half cases of canned pureed turkey sitting on a shelf with a best-by date of 03/07/25. An interview with the Dietary Manager on 04/14/25 at 10:18 AM revealed the turkey should have been used or discarded on or before the best-by date. An interview with the Administrator on 04/17/25 at 3:13 PM revealed he expected food to be used or discarded on or before the best-by date.	F 812		
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.	F 880		5/24/25

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F 880	Continued From page 32	F 880		

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 contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 33 (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 review, staff interviews, and review of the facility's policies and procedures, the facility staff failed to follow infection control procedures when Nurse #1 did not don a gown while administering Resident #51's tube feeding for 1 of 5 staff members observed for infection control practices. The findings included: Review of the facility's undated policy for Enhanced Barrier Precautions revealed that gowns and gloves should be worn when performing high contact resident care activities such as device care or use with central lines, urinary catheters, feeding tubes, tracheostomies or ventilators. An observation on 04/16/25 at 11:59 AM of Nurse #1 entering Resident #51's room that had a sign on the door for Enhanced Barrier Precautions which instructed staff to don gloves and gown.	F 880	1.On 4/16/2025 Nurse #1 was educated. On 5/12/2025 Nurse #1 will be given corrective action for deficient practice. 2.On 5/9/2025 an audit was completed by the Director of Nursing Services with staff on correctly using Enhanced Barrier Precautions. Any deficiencies were corrected at that time. 3.Relias education Diversicare Enhanced Barrier Precautions presentation was assigned and will be complete for all nurses by 5/23/25. Relias education Diversicare Enhanced Barrier Precautions will be included in orientation for newly hired nurses. 4.The Director of Nursing Services or designee will do three random observations weekly for 4 weeks to ensure compliance of enhanced barrier precautions; any deficient practice will be addressed with re-education at the time of deficient practice. Any ongoing deficiency	

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F 880	Continued From page 34 Nurse #1 entered the room and informed Resident #51 she was going administer his tube feed, washed her hands, and applied clean gloves. Nurse #1 proceeded to attach the tube extension set to the gastrostomy tube (feeding tube surgically inserted into the stomach) and administered the bolus tube feeding. An interview with Nurse #1 on 04/16/25 12:01 PM revealed that she did not need to put on a gown for the administration of a tube feed. She stated that she thought the sign was for Resident #51's roommate and that she wasn't sure. A phone interview on 04/16/25 at 1:05 PM with the Infection Preventionist revealed that the Enhanced Barrier Precaution sign was for Resident #51. She stated that Nurse #1 should have worn gown and gloves for the administration of the tube feeding. She stated that Nurse #1 had been educated on what Enhanced Barrier Precautions were and when they needed to be implemented. She stated that if a staff member was unsure who was on Enhanced Barrier Precautions there was an A or B on the sign on the door or on the back of the door indicating which bed was on precautions. She further stated that there was a list posted at the nurse's station letting staff know which residents were on precautions. A joint interview on 04/16/25 at 12:24 PM with the Administrator and the Administrator in Training (AIT) revealed Enhanced Barrier Precautions were for Resident #51 because of his feeding tube. The AIT stated that during education it was explained that if staff entered a room to provide care in a room that had Enhanced Barrier Precautions sign, and the staff were unsure which	F 880	will be handled through the corrective action process.The Director of Nursing Services will bring the audit findings to the monthly QAPI meeting, the IDT will review the findings, and any deficiencies will be corrected. Completion date 05/24/2025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 resident the signs were for then the staff should assume it applied to both residents and put on the appropriate personal protective equipment (PPE). The Administrator stated that his expectations were that if Enhanced Barrier Precaution signage was present that staff put on the appropriate PPE when providing direct patient care.	F 880		

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:
	345193	A. BUILDING: _____ B. WING _____	4/17/2025

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 1 of 2 closed records reviewed for discharge (Resident #71). Findings included: Resident # 71 was admitted to the facility 01/19/25 with a diagnosis including myocardial infarction (heart attack). The 5-day Minimum Data Set (MDS) assessment dated 01/24/25 revealed Resident #71 was cognitively intact and planned to discharge to the community. Review of the medical record revealed Resident #71 was discharged home 01/28/25. Review of the "Discharge Summary/Plan" dated 01/28/25 for Resident #71 revealed the sections completed on the discharge summary were the "Social Service Section", "Discharge to Community", "Discharge Plan", "Social Service", and "Nursing". The "Activities", "Rehab", and "Dietary" sections were blank. An interview with the Social Worker (SW) on 04/16/25 at 3:33 PM revealed she initiated the "Discharge Summary/Plan" and was responsible for completing the "Social Service Section", "Discharge to Community", "Discharge Plan", and "Social Service" areas of the summary. She stated that each department was responsible for completing their section and she was not sure who was responsible for ensuring the discharge summary was completed before a resident was discharged home.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Continued From Page 1

An interview with the Admission/Discharge Nurse on 04/17/25 at 9:20 AM revealed the SW initiated the "Discharge Summary/Plan" and each department completed their assigned section. She stated she was not sure who was responsible for ensuring the "Discharge Summary/Plan" was completed before a resident was discharged home.

An interview with the Activities Director on 04/17/25 at 11:56 AM revealed she was responsible for completing the "Activities" section of the "Discharge Summary/Plan". She stated the "Activities" section should have been completed for Resident #71's discharge summary dated 01/28/25 and it was overlooked.

An interview with the Dietary Manager on 04/17/25 at 1:35 PM revealed she was responsible for completing the "Dietary" section of the "Discharge Summary/Plan". She stated the "Dietary" section should have been completed for Resident #71's discharge summary dated 01/28/25 and it was overlooked.

An interview with the Rehab Director on 04/17/25 at 1:55 PM revealed she was responsible for completing the "Rehab" section of the "Discharge Summary/Plan". She stated she should have completed "Rehab" section of Resident #71's discharge summary but she forgot.

In an interview with the Director of Nursing (DON) on 04/17/25 at 2:04 PM she confirmed the "Discharge Summary/Plan" was the facility's equivalent of a recapitalization of stay. She stated each department was responsible for completing their section of the discharge summary and the Admission/Discharge Nurse was responsible for ensuring the document was completed before a resident was discharged home.

An interview with the Administrator on 04/17/25 at 3:17 PM revealed he expected each department to complete their section on the discharge summary and the "Discharge Summary/Plan" should be completed before a resident was discharged home.