STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD , NEBO, North Carolina, 28761

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 06/16/25 through 06/20/25. The credible allegation was validated on 06/24/25, therefore, the exit date was changed to 06/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: H33R11.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 06/16/25 through 06/20/25. The credible allegation was validated on 06/24/25, therefore the exit date was changed to 06/24/25. Event ID: H33R11. The following intakes were investigated: NC00231314, NC00230926, NC00230278, NC00229874, NC00229848, NC00229768, NC00229571, NC00229467, NC00229389, NC00229251, NC00227229, NC00227085, NC00226765, NC00226626, NC00224771, NC00224559, NC00223754, NC00223706, NC00221502, and NC00220113. 16 of 55 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 and F689 at a scope and severity of J. The tags F684 and F689 constitued Substandard Quality of Care. Immediate jeopardy began on 03/26/25 and was removed on 06/20/25. An extended survey was conducted.	F0000		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12	F0602	F 602 Free of Misappropriation/Exploitation Resident #117 did not experience any pain as a result of the missed dose of Methadone as evidence by an	07/22/2025

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

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

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F0602 SS = D	Continued from page 1 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 reviews, and resident, staff, Physician Assistant (PA), and Physician interviews, the facility failed to protect resident's right to be free of misappropriation of controlled substances for 1 of 3 residents reviewed for misappropriation of resident property (Resident #117). The findings included: The facility's Abuse, Neglect, Exploitation, and Misappropriation policy, last revised on 09/01/2024, revealed in part the facility would ensure all residents were free from misappropriation of property. Resident #117 was admitted to the facility on 11/13/2024 with diagnoses of left clavicle fracture, multiple fractures of the pelvis, left hip fracture, left leg fracture, and chronic pain. A review of the physician's order dated 11/25/2024 revealed Resident #117 had an order for 10 milligrams (mg) of Methadone (an opioid that acts on the central nervous system to relieve pain); give 35 mg/3.5 tablets twice a day for pain (9:00 AM and 9:00 PM). A review of Resident #117's quarterly Minimum Data Set (MDS) assessment dated 02/26/2025 revealed Resident #117 had moderately impaired cognition. The MDS also revealed Resident #117 received scheduled opioid pain medications during the 7-day look back period. Review of Resident #117's April 2025 Medication Administration Record (MAR) revealed Methadone 35 mg scheduled for 9:00 AM on 04/16/2025 was not administered and was sign off as "not available".	F0602	Continued from page 1 interview conducted by the Director of Nursing on 4/17/2025. On 4/17/2025 the Director of Nursing and Unit Managers audited all current residents narcotics with the narcotic declining inventory sheet for discrepancies. No discrepancies were identified. Education was initiated 7/17/25 in person and via phone for all licensed nursing staff and medication aides by the Director of Nursing or Staff Development Coordinator on the facility policy related to maintaining narcotics on the medication carts and signing of shift-to-shift count sheets, counting and verifying the narcotic count is correct with the education. Education included expectations and requirements regarding a second witness for all wasted controlled substances. Additional education topics provided included abuse, neglect, and exploitation regarding controlled substance administration and accountability, diversion, misappropriation of facility and/or resident property. Clinical nurses and medication aides, including agency clinical staff will not be permitted to work until education is completed after 7/22/25. Education will be a part of the orientation process for all new hire and agency licensed staff prior to working their first shift. The Director of Nursing and/or Designee will audit medication carts related to the narcotic count being correct to ensure the medication cards matches the control sheets and the shift-to-shift count sheets are being signed at the start and at the end of the shift. The audit will also include review of narcotic declining sheets to ensure that wasted narcotics have 2 signatures. Auditing will be completed 5X per week Monday through Friday for 2 weeks, then 3 x per week Monday-Friday for 2 week, then once a week Monday-Friday for 8 weeks. The finding of the audit will be present to the QAPI committee monthly for 3 months Date of Compliance 7/22/25	

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F0602 SS = D	Continued from page 2 Review of the Pharmacy Consolidated Delivery Sheet revealed 210 tablets of Methadone 10 mg for Resident #117 was delivered to the facility on 04/16/2025 at 4:00 PM. Review of Resident #117's April 2025 MAR revealed Methadone 35 mg scheduled for 9:00 PM on 04/16/2025 was documented as administered by Nurse #3. Review of Resident #117's declining inventory sheet for Methadone 10 mg tablets; give 35mg/3.5 tablets twice a day for pain revealed one dose of Methadone was signed out by Nurse #3 on 04/16/2025 with no indication of what time the medication was signed out or administered. On 04/17/2025 one dose of Methadone was signed out by Nurse #3 on 04/17/2025 at 10:00 PM. Review of the nursing assignment sheets dated 04/16/2026 revealed Nurse #3 was assigned to Resident #117 from 3:00 PM on 04/16/2025 through 04/17/2025 at 7:00 AM. Nurse #3 was not working on 4/17/25 at 10:00 PM. The initial allegation report dated 04/17/2025 revealed the Director of Nursing (DON) became aware of the misappropriation of resident's property on 04/17/2025 at 12:00 PM when Nurse #2 reported the declining inventory sheet revealed a discrepancy with Resident #117's pain medication on 04/16/2025. On 04/17/2025, an internal investigation was initiated regarding the allegation of misappropriation of property for Resident #117. Nurse #3's agency was contacted, and Nurse #3 was placed on the "do not return" list. An interview on 06/18/2025 at 1:15 PM with Nurse #2 revealed on 04/17/2025 at approximately 7:15 AM during the medication count, Nurse #2 observed Resident #117's declining inventory sheet for Methadone 35 mg. Resident #117's Methadone was signed out twice between second and third shift on 04/16/2025. Nurse #2 revealed that Nurse #3 stated that she did not write the time down that she gave a dose but that she did give the medication to Resident #117 two times during her shifts. Nurse #2 stated that Nurse #3 did not fill in the time she gave the medication before leaving the facility. Nurse #2 stated Resident #117's medications should have been given every 12 hours at 9:00 AM and 9:00 PM. Nurse #2 also stated that Resident #117 stated he was only given one dose of his Methadone. Nurse #2	F0602		

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F0602 SS = D	Continued from page 3 stated that she notified the DON at approximately 11:15 AM on 04/17/2025. Review of Nurse #3's telephone statement taken by the DON on 04/18/2025 revealed Nurse #3 stated that Resident #117's medication came in from the pharmacy on her shift around 4:00 PM and she thought it was okay to administer the medication at approximately 6:00 PM in place of the missed morning dose which had not arrived from the pharmacy. Nurse #3 also stated that she did not contact the physician about the missed dose and did not receive a one-time order from the physician to administer the medication early on 04/16/2025. Nurse #3 stated she administered Resident #117's Methadone 35 mg at 6:00 PM and again at 10:00 PM on 04/16/2025. Multiple unsuccessful attempts were made to contact Nurse #3. The investigation report (5-day) dated 04/22/2025 revealed the Director of Nursing (DON) was alerted by Nurse #2 on 04/17/2025 at 12:00 PM that Resident #117's declining inventory sheet revealed Methadone 35 mg was signed out on 04/16/2025 by Nurse #3 with no indication of what time the medication was administered. Nurse #3 signed out a second dose of Methadone with the date and time reading 04/17/2025 at 10:00 PM. Nurse #3 started her shift on 04/16/2025 at 3:00 PM and her shift ended on 04/17/2025 at 7:00 AM. Nurse #3 was not on duty on 04/17/2025 at 10:00 PM. The investigation report revealed statements had been obtained from Nurse #2 and Nurse #3. Nurse #3 was instructed by the DON to contact her agency in regard to submitting a statement and a drug screen. Nurse #3 submitted to drug testing on 04/22/2025 and the results were negative. Per the facility's investigation report dated 04/22/2025, an audit was performed on 04/17/2025 of the declining inventory sheets and each medication on all the medication carts to verify that all narcotic medications and declining inventory sheets were present and accurate. No additional discrepancies were found. The diversion was reported to the local police and the local Department of Social Services on 04/17/2025. Nurse #3 was reported to the Board of Nursing on 04/21/2025. A review of the pharmacy receipt dated 04/22/2025 revealed Resident #117's account was credited for one	F0602		

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F0602 SS = D	Continued from page 4 dose of Methadone 35 mg. An observation and interview was conducted with Resident #117 on 06/17/2025 at 2:13 PM. Resident #117 was sitting up in his wheelchair watching television. Resident #117 appeared comfortable and did not verbalize any complaints of pain or discomfort. Resident #117 stated he has had issues with pain for a long time because he was in an automobile accident in 2023 and suffered severe injuries including multiple broken bones and abdominal trauma. Resident #117 further stated that he had chronic pain as a result of his automobile accident and had received oxycodone for a very long time for pain control, but he was now taking Methadone twice a day. He also stated that the Methadone controlled his pain. Resident #117 stated that he remembered the day when he did not get his morning dose of Methadone. Resident #117 stated that he did not feel well the entire day, and he didn't have any energy, but he did not know if it was because he didn't get his pain medication or not. An interview was conducted with the DON on 06/18/2025 at 3:25 PM. The DON revealed that on 04/17/2025 at approximately 12:00 PM, Nurse #2 notified her that Nurse #3 had signed out 2 doses of Methadone 35 mg on the declining inventory sheet for Resident #117. The DON further explained that Resident #117 stated he only received his nighttime dose of Methadone on 04/16/2025 around 10:00 PM that night. The DON stated that Nurse #3 was on duty in the facility beginning at 3:00 PM on 04/16/2025 and ended her shift at 7:00 AM on 04/17/2025. The DON also stated that she reported the incident to the Administrator and the facility initiated an internal investigation. An interview with the Physician was conducted on 06/19/2025 at 1:19 PM. The Physician revealed she was very familiar with Resident #117, but she was not aware that he missed a dose of his scheduled pain medication. The Physician also stated that she had recently visited Resident #117, and his pain was well controlled with his Methadone. She also stated that Resident #117 had not mentioned anything about having missed a dose of Methadone or having uncontrolled pain or discomfort. An interview with the Physician Assistant (PA) on 06/19/2025 at 2:15 PM revealed he was familiar with Resident #117 who suffered from chronic pain due to an automobile accident which resulted in multiple	F0602		

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F0602 SS = D	Continued from page 5 fractures and a prolonged hospital stay. The PA stated that Resident #117 had received oxycodone (a pain mediation used to treat severe pain) initially when he was admitted to the facility but had transition to Methadone for his chronic pain. The PA revealed he recalled being told about the missing Methadone dose but did not recall the details about it. He stated Resident #117's pain was well controlled with Methadone 35mg twice a day and he didn't think Resident #117 suffered any ill-effects from the missed dose. An interview was conducted with the Administrator on 06/19/2025 at 4:10 PM. The Administrator explained she notified the pharmacy to reimburse Resident #117 for one dose of Methadone. The Administrator further stated they had also reported Nurse #3 to the North Carolina Board of Nursing (NCBON), notified local law enforcement, and the Department of Social Services. She explained they had done in-service education with all staff on abuse and neglect which included misappropriation of resident property. She further explained the education included misappropriation of resident's medications including narcotics for all nursing staff. The education also included the proper procedure for signing out narcotics on the declining inventory sheets. According to the Administrator, since putting these measures in place there had been no further issues with missing narcotic medications. A joint interview was conducted with the Administrator and the Director of Nursing (DON). The DON revealed the facility launched an in-service related to controlled medication process and accountability immediately after the incident to re-educate all the licensed nurses and medication aides. The DON or designee audited the medication carts in-person randomly to ensure all controlled medication counts were conducted appropriately and the declining narcotic count sheets were documented properly. The Administrator stated the interventions were successful as the facility did not have any similar diversion issues since then. The facility provided a plan of correction for past non-compliance with a completion date of 04/23/2025. The plan of correction could not be accepted by the state agency due to lack of interventions to support the prevention of misappropriation of resident property. The plan was not accepted due to the following:	F0602		

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F0602 SS = D	Continued from page 6 1. The plan did not address a review of the screening and hiring processes. 2. The plan did not include a resident assessment from the physician assistant or the physician, only nursing assessments were included. 3. The plan did not address how the non-interviewable residents were assessed. 4. The plan did not include pharmacy's role in monitoring of controlled substances. 5. The plan did not include how the education on abuse and misappropriation of property was going to prevent further misappropriation.	F0602		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F0641	F641 This REQUIREMENT is not met as evidenced by the following: The facility failed to accurately code Minimum Data Set (MDS) assessments for 1 out of 2 residents reviewed in the area of dialysis and 1 out of 1 resident reviewed for hospitalization. How corrective action will be accomplished for each resident found to have been affected by the deficient practice: MDS Assessment ARD 5/17/2025 for Resident #10 was corrected on 6/26/2025 for O0100J1 to reflect dialysis during the look back period on 5/13/2025 by the MDS Coordinator. MDS Assessment ARD 4/10/2025 for Resident #126 was corrected on 6/26/2025 for A2105 to reflect accurate discharge destination to the community by the MDS Coordinator. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice All current residents receiving dialysis have the potential to be affected by the deficient practice. All current residents were reviewed for receiving dialysis on 6/26/2025 by the MDS Coordinator for accurate coding of O0100J1. No other MDS assessments were found to be deficient. All discharge MDS assessments completed x 30 days were	07/22/2025

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F0641 SS = D	Continued from page 7 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for dialysis (Resident #101) and 1 of 1 resident reviewed for hospitalization (Resident #126). Findings included: 1. Resident #101 was initially admitted to the facility on 02/20/24 and was readmitted to facility on 05/13/25. Resident #101's diagnoses include end-stage kidney disease. A review of physician orders revealed an order dated 12/11/24 for hemodialysis every Monday, Wednesday, and Friday at 11:30 AM at the local dialysis center. A review of the quarterly MDS assessment dated 05/17/25 revealed dialysis was not coded on the assessment. An interview with the MDS Coordinator on 06/20/25 at 10:37 AM revealed that Resident #101's most recent MDS assessment had been completed by a remote nurse who was in training. The MDS Coordinator stated that the nurse was given a form with Resident #101's information and dialysis was noted on there but was not coded correctly on the assessment. The MDS Coordinator stated the miscoding was an error due to an oversight. An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM revealed the resident's MDS assessments should be accurate and reflect the resident's care needs. An interview with the Administrator on 06/19/25 at 4:15 PM revealed that it was important that MDS assessments	F0641	Continued from page 7 reviewed for accurate coding of destination discharge status A2105 on 6/26/2025 by the MDS Coordinator. No other MDS assessments were found to be deficient. "Measures to be put in place or systemic changes made to ensure practice will not re-occur: The MDS Coordinators were educated by Regional of Director of Reimbursement on 7/08/2025 regarding accuracy of coding O0100J1 and A2105. "How facility will monitor its performance to make sure that solutions are sustained: All MDS assessments completed for residents receiving dialysis will be audited for accurate coding of O0100J1 weekly x 4 weeks, then biweekly x 2, then each month thereafter by the MDS Coordinator with review by the Regional MDS Consultant. The MDS Coordinator will complete any needed correction of the MDS assessments. Results of the audit will be presented to the monthly QAPI meeting by the MDS Coordinator or designee. All MDS discharge assessments will be audited for accurate coding of A2105 weekly x 4 weeks, then biweekly x 2, then each month thereafter by the MDS Coordinator with review by the Regional MDS Consultant. The MDS Coordinator will complete any needed correction of the MDS assessments. Results of the audit will be presented to the monthly QAPI meeting by the MDS Coordinator or designee. Date of Compliance is 7/22/2025.	

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F0641 SS = D	Continued from page 8 were completed accurately. 2. Resident #126 was admitted to the facility on 02/20/25, readmitted on 03/06/25 and discharged on 04/10/25. A progress note dated 04/10/25 indicated Resident #126 was discharged home with a friend and his medications were given to him upon discharge. Resident #126's discharge Minimum Data Set (MDS) assessment dated 04/10/25 revealed he was discharged to short term general hospital. During an interview on 06/20/25 at 3:19 PM with the MDS Coordinator and the Regional MDS Coordinator they stated Resident #126 was discharged home with a friend and his assessment was miscoded as being discharged to short term general hospital. The MDS Coordinator stated she would amend the discharge assessment and correct the assessment to reflect the resident was discharged to the community. An interview on 06/20/25 at 4:00 PM with the Administrator revealed she felt like the error was a keying error and the MDS Coordinator was modifying the MDS for resubmission.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F0656	F656: This REQUIREMENT is not met as evidenced by the following: The facility failed to develop an individualized, person-centered comprehensive care plan in the areas of pain management and opioid (pain medication). How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Care plan for resident #117 was updated for both opioid medication use and for pain management on 6/18/2025. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: All current residents who are receiving an opioid pain medication regimen for pain management have the	07/22/2025

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F0656 SS = D	Continued from page 9 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan in the areas of pain management and opioid (pain medication) use for 1 of 4 residents whose comprehensive care plans were reviewed (Resident #117). Findings included: Resident #117 was admitted to the facility on 11/13/2024 with diagnoses of left clavicle fracture, multiple fractures of the pelvis, left hip fracture, left leg fracture, and chronic pain.	F0656	Continued from page 9 potential to be affected by the alleged deficient practice. All current residents opioid and pain care plans were audited for accuracy in relation to their pain management and medication use on 6/18/2025 by the MDS Coordinator. Any inaccuracies were corrected upon discovery during the audit process on 6/18/2025 by the MDS Coordinator. Measures to be put in place or systemic changes made to ensure practice will not re-occur: MDS Coordinator was educated by the Regional Director of Clinical Reimbursement or designee by 7/01/2025 regarding the need to accurately reflect the pain management and medication use. Measures to be put in place or systemic changes made to ensure practice will not re-occur: All care plans for residents receiving pain management and opioid pain medications will be audited weekly x 4 weeks, then biweekly x 2 weeks, then each month thereafter by the MDS Coordinator with review by the Regional MDS Consultant. The MDS Coordinator will complete any needed correction of care plans identified. Results of the audit will be presented to the monthly QAPI meeting by the MDS Coordinator or designee. Date of Compliance is 7/22/2025.	

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F0656 SS = D	Continued from page 10 A review of Resident #117's medication orders revealed: 1. Methadone 35 milligrams (mg) twice a day for pain; start date: 11/25/2024. 2. Cyclobenzaprine 10 mg three times a day for muscle spasms; start date: 11/25/2024. 3. Gabapentin 600 mg three times a day for neuropathy (nerve pain); start date: 11/25/2024. 4. Tylenol 650 mg every 8 hours as needed for pain; start date: 02/14/2025. Review of Resident #117's comprehensive care plan dated 02/01/2024 and revised on 03/01/2025 did not reveal a care plan had been developed related to pain management or the use of opioid medications. A review of Resident #117's quarterly Minimum Data Set (MDS) assessment dated 02/26/2025 revealed Resident #117 had moderately impaired cognition. He received opioid and scheduled pain medication during the look back period. Review of Resident #117's April 2025 Medication Administration Record (MAR) revealed he received all scheduled does of both Cyclobenzaprine and Gabapentin and all but one dose of Methadone, which was documented as "not available." He did not request any "as needed" pain medications. A joint interview was conducted with the MDS Nurse #1 and the Regional MDS Coordinator on 06/18/2025 at 3:00 PM. MDS Nurse #1 stated Resident #117's MDS assessment dated 02/26/2025 revealed he received scheduled pain medication. The Regional MDS Coordinator stated that the quarterly MDS was accurate. She further stated Resident #117s care plan should include pain management and the use of opioids. MDS Nurse #1 further stated that she was not sure how the care plan for pain management and opioid use was overlooked. An interview was conducted with the Administrator on 06/18/2025 at 3:36 PM. The Administrator stated she	F0656		

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F0656 SS = D	Continued from page 11 expected the care plan to reflect the resident's clinical condition and care needs including pain management and opioid use.	F0656		
F0658 SS = E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, resident, staff and provider interviews, the facility failed to administer medications as ordered by the physician for 1 of 2 residents reviewed for pain medications (Resident # 106). The findings included: Resident #106 was admitted to the facility on 4/2/2024 with diagnosis that included nontraumatic subarachnoid hemorrhage from unspecified intracranial artery (a type of stroke where bleeding occurs in the space between the brain and the skull and the source of the bleeding is not due to trauma or a known cause), chronic respiratory failure with hypoxia, pressure ulcer sacral region stage four, chronic pain and persistent vegetative state. The quarterly minimum data set (MDS) dated 4/16/2025 revealed Resident #106 was in a persistent vegetative state and indicated Resident #106 received opioid medication. Review of Resident #106's care plan revealed Resident #106 was care planned for minimal consciousness secondary to subarachnoid hemorrhage and persistent vegetative state with interventions that included monitor the patients neurological state. Resident #106 was care planned for alteration in	F0658	F 658 Professional Standards Resident #106 has been consistently receiving her Fentanyl patch as ordered for the past 60 days. On 7/16/2025 a comprehensive MAR to cart narcotic audit was conducted by the Director of Nursing and Unit Manager of all residents who receive fentanyl patches to ensure they were present and/or refills requested. Any identified concerns were addressed immediately. On 7/17/2025 the Staff Development Coordinator initiated education with all licensed nurses and medication aides including agency licensed nurses on notification of the pharmacy if a narcotic is not available, requesting a prescription from a medical provider in a timely manner to avoid a gap in medication administration when refilling a controlled medication and notification of an unavailable narcotic to the physician and Director of Nursing. All licensed nurses and medication aides, including agency licensed nurses who have not received this education by 7/22/25 will not be allowed to work until this training has been completed. This education will be included in the new hire and agency orientation process for all licensed nurses to ensure compliance. The Director of Nursing or designee will audit each unit's medication cart, once a week x 4 weeks then monthly x 2 months to ensure accurate acquiring of scheduled narcotics for administration. The Director of Nursing will present the findings of these audits to the QAPI committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained ongoing, and determine the need for further monitoring. Date of compliance: 7/22/2025	07/22/2025

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F0658 SS = E	Continued from page 12 neurological status related to non traumatic subarachnoid hemorrhage from unspecified intracranial artery with interventions that included pain management as needed. Resident #106 was care planned for potential/actual pain with interventions that included administer analgesia as per orders and monitor/record/report to nurse any signs or symptoms of nonverbal pain. Resident #106 was care planned for pressure ulcer related to immobility, admitted with stage 4 sacral ulcer present on admission with interventions that included administer medications as order. Review of Resident #106's physicians' orders revealed the following: A physician's order dated 7/4/2024 that read: fentanyl transdermal patch 72 hour 25 micrograms (MCG) per hour apply 1 patch transdermally every 72 hours for pain and remove old patch per schedule. A physician's order dated 8/27/2024 that read: oxycodone HCL oral tablet 5 milligrams (mg) give one tablet via PEG (a feeding tube inserted through the abdominal wall into the stomach) tube three times a day for sacral wound pain. Review of the Medication Administration Record (MAR) for July 2024 revealed documentation on 7/25/2024 by Nurse #6 that Resident #106's fentanyl patch was not applied as ordered due to not being available. Review of progress notes revealed an electronic Medication Administration Record (eMAR) administration note dated 7/25/2024 at 5:26 PM written by Nurse #6 that revealed fentanyl transdermal patch 25 MCG was awaiting order. Nurse #6 was unable to be reached for interview, the facility was unable to obtain a working number. Review of the MAR for September 2024 revealed documentation on 9/11/2024 by Nurse #12 that Resident #106's fentanyl patch was not applied as ordered due to not being available.	F0658		

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F0658 SS = E	Continued from page 13 Review of progress notes revealed an eMAR administration note dated 9/11/2024 by Nurse #12 that revealed fentanyl transdermal patch was "awaiting arrival from pharmacy. Provider aware." During an interview on 6/19/2025 at 9:51 AM Nurse #12 stated she was familiar with Resident #106. Nurse #12 did not recall a specific instance when Resident #106 did not have her fentanyl patch available. Nurse #12 stated when a resident needs a controlled medication refilled, the prescription must be printed for the provider to sign and then faxed to the pharmacy. Nurse #12 stated if a resident does not have scheduled medication available, she would notify the provider, and make sure the medication had been reordered from the Pharmacy. Review of the MAR for October 2024 revealed documentation on 10/14/2024 by Nurse #12 that Resident #106 ' s fentanyl patch was not applied as ordered due to not being available. Review of progress notes revealed an eMAR administration note dated 10/14/2024 by Nurse #12 that revealed fentanyl transdermal patch "new patch is on order." During an interview on 6/19/2025 at 9:51 AM Nurse #12 stated she normally notified the provider when a medication was not available. Nurse #12 stated she may have forgot to document notification but if she documented it was on order, she had ordered it from the pharmacy and that meant the provider had signed a script. Review of the MAR for April 2025 revealed documentation on 4/12/2025 by Nurse #8 that Resident #106's fentanyl patch was not applied as ordered due to not being available. Review of Progress notes revealed an eMAR administration note dated 4/12/2025 8:47 PM written by Nurse #8 that revealed Resident #106's fentanyl patch was unavailable.	F0658		

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F0658 SS = E	Continued from page 14 During a telephone interview on 6/20/2025 at 3:33 PM Nurse #8 stated she was an agency nurse at the facility and there were times when controlled medications were not available at the facility. Nurse #8 verified she had worked with Resident #106 on 4/12/2025. Nurse #8 stated that when she reordered controlled medications, she clicked the reorder button located on the eMAR, and stated she did not call the provider. Nurse #8 stated she did not know a prescription had to be printed, signed by the provider and faxed to the pharmacy. Nurse #8 stated since she was agency and did not always work the same hall she normally did not reorder controlled medication. Nurse #8 stated recently the unit managers rounded on the carts and reordered controlled medications that were low on supply. Review of the MAR for April 2025 revealed documentation on 4/15/2025 by Nurse #9 that Resident #106's fentanyl patch was not removed or applied as ordered. Review of progress notes revealed an eMAR administration note dated 4/15/2025 at 6:16 PM written by Nurse #9 that read "left old patch on until new script is signed for medication to be sent." During a telephone interview on 6/19/2025 at 10:26 AM Nurse #9 verified she worked with Resident #106 on 4/15/2025 from 3:00 PM to 11:00 PM. Nurse #9 stated Resident #106 did not have a fentanyl patch available. Nurse #9 stated she did not leave an old patch on that old patches were removed and wasted so no patch was available to be removed. Nurse #9 stated when a resident did not have a scheduled medication she would check the back up medication, and if the medication was not available she would print off a prescription to be signed by the provider and faxed to the pharmacy. Review of the MAR for May 2025 revealed documentation on 5/12/2025 by Nurse #10 that Resident #106's fentanyl patch was not removed or applied as ordered. Review of progress notes revealed eMAR administration note dated 5/12/2025 at 9:53 PM written by Nurse #10 that read : fentanyl patch "not available." Also revealed an eMAR administration note dated 5/12/2025 at 9:54 PM written by Nurse #10 that read: fentanyl patch not removed.	F0658		

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F0658 SS = E	Continued from page 15 Nurse #10 was unable to be reached for interview, the facility was unable to obtain a working number. Review of the MAR for May 2025 revealed documentation on 5/15/2025 by Nurse #11 that Resident #106's fentanyl patch was not available. Review of progress notes revealed eMAR administration note dated 5/15/2025 at 10:46 PM written by Nurse #11 that read: "none available. Called on call, and he was unable to order a script but said to take old patch off and get a script tomorrow on day shift." Nurse #11 was unable to be reached for interview, the facility was unable to obtain a working number. An observation of Resident #106 was conducted on 6/16/2025 at 1:45 PM. Resident #106 was lying in her bed. Resident #106 was not able to respond or answer any questions. Resident #106 was observed to have regular breathing and appeared comfortable and in no distress. Resident was noted to have a fentanyl transdermal patch to her left upper chest. During an interview on 6/19/2025 at 11:07 AM Nurse #12 stated she goes through her narcotic drawer every day that she works to see what medications are low, then she prints the scripts for medications that are needed and Nurse #12 or the unit managers deliver the scripts to the provider to be signed and then the scripts are faxed to the pharmacy. Nurse #12 stated she sometimes forgot to look at the patches when she checked the cassettes but when patches were ordered the pharmacy sent them as soon as possible. During an interview on 6/19/2025 at 11:21 AM the Physicians Assistant (PA) stated he did not think it was significant that Resident #106 had missed 1 or 2 applications of her scheduled fentanyl patch because Resident #106 also received scheduled oxycodone and if the staff had been concerned Resident #106 was having increased pain they would have asked for a PRN to be ordered. The PA stated he had signed refill requests for the fentanyl patch but did not recall specific dates. The PA stated he knew they had been out at one point but was not concerned due to Resident #106's scheduled pain medication.	F0658		

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F0658 SS = E	Continued from page 16 During an interview on 6/19/2025 at 1:21 PM the Physician stated Resident #106 is in a vegetative state and non-verbal, and due to her severe brain damage pain response or reaction is hard to judge. The Physician stated she ordered the fentanyl patch for Resident #106 to make sure she was not in pain, but missing one dose would probably not cause significant discomfort, but missing two doses may cause some discomfort. The Physician stated since Resident #106 also had scheduled oxycodone it would help with any withdrawal symptoms. The Physician stated Resident #106 had sweating at her baseline so the only way to know if she had effects from missing her fentanyl doses would be vomiting or diarrhea. The Physician stated a resident who could vocalize might say they felt bad from missing two doses of a fentanyl patch. The Physician stated she was not aware of missed applications of Resident #106's fentanyl patch. During an interview on 6/19/2025 at 5:13 PM the Director of Nursing (DON) stated that she had started to transition to the Unit Managers reordering the narcotics. The DON stated the unit managers would go through the carts at least once a week to print scripts for the narcotics that needed to be reordered, then take the scripts to the provider to be signed then unit managers would fax the scripts to the pharmacy. The DON stated it had only been about a month since she had started this new process. The DON stated she expected the residents to have ordered medications available at the facility to be administered as scheduled. The DON expected narcotics to be reordered when needed and for the nurse to notify the provider of medications that were unavailable. During an interview on 6/20/2025 at 7:55 AM the Administrator stated she expected residents ordered medication to be available from the pharmacy, reordered when the supply is low. The Administrator would expect the provider to be notified if medication was not available.	F0658		
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a	F0684	F-684 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. On 3/26/25, Resident #101 was picked up by a contract transportation company to transport the resident round trip to a dialysis appointment. While on the return	07/22/2025

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F0684 SS = SQC-J	Continued from page 17 resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff, Nurse Practitioner (NP), Physician Assistant (PA), Physician, and Contract Transport Company Owner interviews, the facility failed to complete a clinical assessment of injury after a fall. Resident #101 was being transported back from a medical appointment in a contract transport van in her specialized wheelchair. Resident #101 was not secured in wheelchair according to the manufacturer's instructions. Driver #1 hit a bump pulling into the facility entrance which caused Resident #101 to fall forward, landing partially out of her wheelchair with her legs under the chair. Driver #1 notified staff at the facility Resident #101 had fallen. Nursing Assistant (NA) #1 and NA #2 entered the van and lifted Resident #101 back into her chair without having the resident assessed for injuries by a nurse or medical provider. NA #2 returned Resident #101 to her room and notified Nurse #1 (agency nurse) who then completed an assessment of Resident #101. NA #1 and NA #2 were not qualified to provide a comprehensive physical assessment to determine if Resident #101 sustained any acute injury. In addition, the facility also failed review a resident's electronic medical record for x-ray results after Resident #15's fall on12/28/24 which resulted in a delay in medical treatment. The x-ray was completed on 12/29/24 and the report was sent to the facility that same day that indicated Resident #15 had an acute right femoral intertrochanteric fracture. The x-ray results were reported to the Nurse Practioner (NP) on 12/30/24 and when assessed by the NP Resident #15 reported a pain level of 10 (based on a scale of 1 to 10 with 10 being the worst pain). Resident #15 was sent to the emergency department on 12/30/24 and underwent a closed reduction and cephalomedullary (hardware used to fix broken bones) nail fixation and returned to the facility on 01/03/25. This deficient practice affected 2 of 5 residents reviewed for quality of care (Resident #101 and Resident #15). Immediate Jeopardy began on 03/26/25 when Resident #101 was not assessed for injuries by a nurse or medical provider before being moved from the floor of the transportation van after a fall. The immediate jeopardy was removed on 06/20/25 when the facility implemented an acceptable credible allegation for immediate	F0684	Continued from page 17 route back to the facility the contract driver hit a bump when turning into the facility parking lot, causing Resident #101 to slide forward from the chair. The contract driver notified an employee of the facility that Resident #101 had fallen out of chair. Two nursing assistants responded to the contract driver's request for assistance. The nursing assistants went to the transportation vehicle, lifted Resident #101 from the floor of the transportation vehicle, placed Resident #101 back into the wheelchair, then brought the resident into the facility. The nursing assistants notified Nurse #1 of the fall in the transportation vehicle. Resident #101 was assessed by Nurse #1, once the resident arrived in the facility and found no injuries. The physician was notified of the incident with Resident #101 by Nurse #1. The physician gave a verbal order to Nurse #1 to send the resident to the hospital for further evaluation as a precautionary measure. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. As of 6/19/2025, the facility will provide transportation services with our facility van unless the resident requires stretcher service, then they are transported per EMS (ambulance service). The facility will continue with its current process of determining the appropriateness of wheelchair or stretcher transportation for residents. All residents who lack upper body strength and are unable to sit up in a wheelchair will be transported to appointment via stretcher. All appointments are discussed in the morning meeting daily for the next week with the Director of Nursing, Director of Rehabilitation and Administrator. Any resident identified at that time requiring special accommodation for transport will have the change made for transportation. The care plan will be updated when the resident is identified as requiring stretcher transportation, for future reference. The facility van drivers which included 2 alternate drivers (Maintenance Director and Admission Coordinator), were educated by the Director of Facility Services on 6/20/25, to notify a nurse or medical provider if a resident falls while being transported or calling 911 immediately via their personal cell phones. A reminder notice was placed in the transportation	

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F0684 SS = SQC-J	Continued from page 18 jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. Example #2 was cited at a scope and severity of G. The findings included: 1. Resident #101 was initially admitted to the facility on 02/20/24 and was readmitted to facility on 05/13/25. Resident #101's diagnoses include end-stage kidney disease, cerebral infarction (stroke), muscle weakness, and limited mobility. A review of orders revealed an order dated 11/04/24 for apixaban (blood thinner) 5 milligrams by mouth twice daily. A review of the annual Minimum Data Set (MDS) dated 01/21/25 revealed Resident #101 was severely cognitively impaired. Resident #101 utilized a wheelchair for mobility, a mechanical lift for all transfers, and had impairments to both upper and lower extremities with contractures. The MDS also noted Resident #101 received an anticoagulant. The care plan originally initiated 02/20/24 for Resident #101 revealed Resident #101 was at risk for falls due to deconditioning. The stated goal was Resident would be free from falls. Interventions included anticipating Resident's needs, staff would ensure call device was in place, and staff would provide reminders for Resident in fall prevention. The mobility care plan stated goal was Resident #101 would have activities of daily living (ADL) care needs met with assistance from staff. Interventions included assistance for all ADL, and Resident #101 was a 2-person transfer using the mechanical lift. A review of Nurse Aide (NA) #2's written statement dated 03/26/25 revealed front-desk staff had asked her to assist getting Resident #101 out of the transport van when Driver #1 notified staff Resident #101 fell on the transport van. NA #2 saw NA #1 and asked for her	F0684	Continued from page 18 vehicle stating to “call 911 in case of an emergency”. The education also included that a nurse or medical provider must conduct a head-to-toe assessment of the resident prior to being moved. On 6/19/2025, the Administrator in-serviced all department heads (Director of Rehabilitation, Food Service Manager, Environment Service Manager, Activities Director, Human Resources Director, Social Services, Director of Nursing, Business Office Manager, Staff Development Coordinator, MDS Coordinator and Admission Director) on notifying a nurse or medical provider immediately, if notified by the driver of a fall on the van. On 6/19/2025 the Staff Development Coordinator, Director of Nursing, Activities Director and Human Resources Director conducted an in-service for all employees including agency personnel, on what to do if they witness a resident fall in person and via phone. Employees including agency personnel will not be allowed to complete a shift before completion of this training by the Director of Nursing, Staff Development Coordinator or designee. The Staff Development Coordinator, Director of Nursing and Administrator are responsible for ensuring all employees including agency personnel have completed the training. In addition, the orientation process was reviewed and reporting accidents and conducting an assessment prior to moving the resident will be part of the new hire orientation process. Additionally, on 7/18/25, all employees including agency personnel were educated on the importance of why a nurse or medical provider should be notified to assess a resident prior to moving them. No employee will be allowed to work after 7/22/25, until they have received this education. This education will be included in the new hire process for all employees including agency personnel. How facility will monitor its performance to make sure that solutions are sustained: DON or designee will audit falls daily (Monday-Friday) during clinical meeting for appropriate assessment by a nurse prior to transferring the resident following a fall. The Director of Nursing will present the findings	

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F0684 SS = SQC-J	Continued from page 19 help and they both went to the transport van without notifying a nurse. NA #2 wrote she observed Resident #101 "out of her chair, legs folded up under her, leaning to the right side." NA #2 reported she asked Resident #101 if she was ok or if anything hurt, and Resident #101 responded "no." NA #2 further reported she and NA #1 "arm and armed Resident #101 back to her wheelchair." NA #2 then brought Resident #101 back to her hall and notified the nurse. An interview with NA #2 (agency staff) on 06/19/25 at 3:35 PM revealed she had walked by the main entrance when Driver #1 told the front desk staff Resident #101 fell on the transport van and needed help. NA #2 stated she could not recall what staff reported fall to her. NA #2 observed Resident #101 on the van with the buckled seatbelt around her breast and had slid down under the seatbelt. NA #2 stated Resident #101 was seated on the wheelchair footrest with both legs positioned under the chair footrest. NA #2 stated she and NA #1 lifted Resident #101 back into the wheelchair by getting her upper and lower body. They removed Resident #101 from the van via the wheelchair lift and brought Resident inside the facility. NA #2 indicated when Resident #101 was returned to her room, she reported the fall to Nurse #1. NA #2 confirmed Resident #101 was not assessed by the nurse prior to being moved from the floor of the van. She stated Resident #101 was returned to her bed for an assessment by Nurse #1. A review of NA #1's undated written statement revealed at 4:45 PM, NA #2 asked for assistance getting Resident #101 out of the transport van after a fall. NA #1 revealed Driver #1 explained Resident #101 was "adjusting herself during car ride and while pulling into the parking lot, she slid out into van floor." NA #1 observed Resident #101 lying on the floor of the van on right side with her legs bent against the back of the driver's seat and back was on the footrest of the wheelchair. It was noted the seatbelt was around wheelchair. NA #1 and NA #2 "lifted" Resident #101 back into her wheelchair. An interview with NA #1 (agency staff) on 06/19/25 at 3:23 PM revealed she recalled NA #2 requested her help on the transport van because Resident #101 had fallen. NA #1 stated, she observed Resident #101 on the floor of the van when she arrived to assist. NA #1 indicated Driver #1 stated Resident #101 had been fidgeting and he pulled into the facility driveway, hit a bump, and Resident #101 slid out of her chair. She reported	F0684	Continued from page 19 of these audits to the QAPI committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained and determine the need for further monitoring. Alleged immediate jeopardy removal date 6/20/2025 Date of compliance 7/22/2025 The statements included are not admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance with state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the date indicated. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #15 resides in the facility, plan of care reviewed and updated based upon the assessed needs to ensure that adequate supervision is provided. Staff shall maintain timely communication with physicians regarding any accidents, incidents and/or changes of condition. Identification of residents having the potential to be affected by the same deficient practice: On 7/17/25, the Interim Director of Nursing and Unit Managers reviewed all active residents fall incidents from 6/24/2025 to 7/17/2025, to determine if any other outstanding radiology results had not been provided or called in to the providers. No other incidents were identified. Measures / systemic changes made to ensure that the deficient practice will not recur: On 7/17/25, the Interim Director of Nursing initiated in-service training with all licensed nurses including agency licensed nurses regarding their role in ensuring radiology results are communicated timely to the resident’s ordering physician and/or provider. The in-service included the following: (1) radiology	

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F0684 SS = SQC-J	Continued from page 20 Resident #101's back rested on the wheelchair footrest, which was extended out, and both of Resident #101's legs were on the floor under the footrest of her wheelchair. NA #1 reported the seat belt was fastened and was sitting on the back seat area of the wheelchair. NA #1 stated it appeared Resident #101 had slid under the seatbelt. NA #1 revealed she and NA #2 lifted Resident #101 back into the wheelchair. NA #1 reported she grabbed Resident #101's upper body and NA #2 grabbed Resident #101's lower body and they transferred Resident #101 from the floor to the wheelchair. She stated no nurse was notified of the fall or had been present for assessment prior to Resident #101 being lifted back into the wheelchair. NA #1 stated Resident #101 denied pain and asked to get up. Once Resident #101 was back in the wheelchair, NA #1 indicated she left and returned to her assigned hall. Review of facility incident report dated 03/26/25 completed by Nurse #1 stated the NA reported Resident #101 was on the floor of the transport van. Driver #1 reported Resident #101 slid from chair in a curve. No injuries were noted upon nurse assessment by Nurse #1. The physician and responsible party were notified. Resident #101 was transferred to the Emergency Department for evaluation after the incident. Review of nursing progress notes written by Nurse #1 dated 03/26/25 revealed a progress note which stated a NA reported to Nurse #1 Resident #101 was on the floor of the transport van. The note stated Resident #101 was placed back in the wheelchair using a sling. Resident #101 was then transferred to the Emergency Department for evaluation per responsible party's request. A second progress note also written by Nurse #1 dated 03/26/25 stated Resident #101's responsible party called facility and reported Resident #101 had been evaluated at the hospital, had no injury, and would return to the facility. A telephone interview with Nurse #1 (agency nurse) on 06/19/25 at 9:02 AM revealed Nurse #1 was assigned to Resident #101 on 03/26/25 during the shift when Resident #101 slid out of her wheelchair while on transport van. Nurse #1 stated she could not recall specifics but thought Resident #101 used a special chair that reclined and not a regular wheelchair. Nurse #1 stated she could not remember if she went to the van to assess Resident #101. Nurse #1 stated if so, she would have directed staff to get the Resident up with a	F0684	Continued from page 20 results should be communicated to the ordering physician within your shift, (2) After-hours and on weekends, call the on-call physician for notification of results within your shift, (3) Document in the resident records the communication with the ordering physician and availability of the radiology results. If orders are received, document that as well in resident records. All licensed nurses, including agency licensed nurses who have not received this education by 7/22/25 will not be allowed to work until this training has been completed. This education will be included in the new hire and agency orientation process for all licensed nurses to ensure compliance. Facility plans to monitor performance to make sure solutions are sustained: The Director of Nursing or designee will review radiology results daily (Monday –Friday) x 4 weeks then biweekly x 4 weeks, then monthly x 2 months to ensure radiology results have been reviewed and communicated to the ordering physician. The Director of Nursing will present the findings of the audits to the Quality Assurance and Performance Committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained ongoing, and determine the need for further monitoring. Date of compliance 7/22/25	

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F0684 SS = SQC-J	Continued from page 21 blanket or sheet because Resident #101 used a total lift for transfers. Nurse #1 did not know where Resident #101 had fallen out of the chair during the drive, but believed it was not far from the facility. Nurse #1 stated Resident #101 was placed in Resident's room after the incident and Nurse #1 assessed her. The interview further revealed Nurse #1 was an agency nurse and had not worked at facility for months and could not recall the name of the staff member who reported to her that Resident #101 had fallen, but knew it was an NA. Review of the hospital discharge summary dated 03/26/25 revealed Resident #101 was evaluated on 03/26/25 after fall at the Emergency Department. It was noted in the discharge summary that Resident #101 received an anticoagulant. The hospital record stated Resident #101 had no signs of acute injury upon assessment and had no complaints of pain during visit. A computed tomography (CT) of Resident #101's head, thoracic (middle) spine, and lumbar (lower) spine were completed and results indicated no acute injury was noted on the CT. A review of the Transport Company and facility contract dated 08/24/12 revealed the Transport Company would provide "safe transit" which was defined as "transporting patients to required destinations without scare or endangerment." A review of Driver #1's undated statement revealed Driver #1 picked up Resident #101 after her dialysis treatment and secured Resident #101 into the wheelchair inside the transport van using the 4-point anchor system. Driver #1 stated he also secured Resident #101's seatbelt "under her arms and snug around her midsection." Driver #1's statement further revealed when he pulled into the facility entrance, Resident #101 had "slid out from under her seatbelt and was sliding out of her chair." Driver #1 contacted the facility staff for assistance and "observed both NAs lift Resident #101 back into her wheelchair." Driver #1 reported one of the NAs stated Resident #101 "needed a belt to better keep her in her chair as Resident #101 cannot sit up properly." Driver #1 left after Resident #101 was taken back into the facility. A phone interview was attempted with Driver #1 but was unable to be reached. Telephone interviews with the Transport Company Owner	F0684		

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F0684 SS = SQC-J	Continued from page 22 on 06/19/25 at 12:53 PM and 2:44 PM revealed he did recall the incident on 03/26/25 but could not recall who the driver was but would check his records. Transport Company Owner stated he had no written records of the incident but remembered what the driver told him. The Transport Company owner stated Driver #1 told him Resident #101 had not fallen out of the chair, but her buttocks had come out a little forward in her wheelchair when Driver #1 hit a bump pulling into the facility driveway. He reported the Driver #1 parked the transport van, and Resident #101 was on the edge of her wheelchair seat and her seatbelt still held her in the wheelchair. Driver #1 unfastened the seatbelt and lowered Resident #101 to the floor of the van. Driver #1 then entered the facility and notified the staff who helped get Resident #101 up. The Transport Company Owner stated the Driver #1 resigned from the company 6 weeks ago. The Transport Company Owner explained all drivers were trained to stop the van during any adverse event when safe to do so and tend to the residents' needs which Driver #1 did immediately after Resident #101 fell when he pulled into the facility entrance. An interview with the facility PA on 06/20/25 at 10:08 AM revealed Resident #101 was totally dependent on staff for all activities of daily living. The PA stated Resident #101 was severely cognitively impaired, and Resident had very limited mobility due to upper and lower body contractures. He reported Resident #101 was unable to do anything to brace herself or prevent a fall. The PA stated Resident #101 received an anticoagulant (blood thinner) and thus would be at risk for bleeding with any fall or accident. Due to the use of an anticoagulant, bleeding could occur anywhere in the body. With an anticoagulant, the PA indicated he would be most concerned about the possibility of a head injury with bleeding on or around the brain which would be life threatening. The interview further revealed anytime a Resident fell, they would need to be assessed by a nurse before being moved, who would then notify the provider of the fall or any injury. An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM stated NA #1 and NA #2 were agency staff but had fall protocol training prior to starting at facility. The DON stated the NAs should have notified a nurse for a comprehensive assessment prior to Resident #101 being moved. The interview with the Administrator on 06/19/25 at 4:15 PM revealed after the incident, she had	F0684		

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F0684 SS = SQC-J	Continued from page 23 interviewed Driver #1 who stated when he had hit a bump pulling into the facility driveway Resident #101 had slid out of the wheelchair. NA #1 and NA #2 stated the driver reported Resident #101 slid out of chair. The two NAs went out to the van, but did not notify a nurse prior to moving Resident #101 for assessment. The Administrator was aware the nurse had not completed an assessment before staff moved Resident #101. From the Administrator's recollection, Resident #101 had been evaluated at the Emergency Department, and had no injury from the fall. The Administrator indicated she would have expected NAs to notify a nurse to assess Resident #101 for injury prior to moving the resident. The facility was notified of immediate jeopardy on 06/19/25 at 7:35 PM. The facility provided the following plan for IJ removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. On 03/26/25, Resident #101 was picked up by a contract transportation company to transport the resident round trip to a dialysis appointment. While on the return route back to the facility the contract driver hit a bump when turning into the facility parking lot, causing Resident #101 to slide forward from the chair. The contract driver notified an employee of the facility Resident #101 had fallen out of chair. Two nursing assistants responded to the contract driver's request for assistance. The nursing assistants went to the transportation vehicle, lifted Resident #101 from the floor of the transportation vehicle, placed Resident #101 back into the wheelchair, then brought the resident into the facility. The nursing assistants notified Nurse #1 of the fall in the transportation vehicle. Resident #101 was assessed by Nurse #1, once the resident arrived at the facility and found no injuries. The physician was notified of the incident with Resident #101 by Nurse #1. The physician gave a verbal order to Nurse #1 to send the resident to the hospital for further evaluation as a precautionary measure.	F0684		

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F0684 SS = SQC-J	Continued from page 24 All residents in the facility, who are transported for appointments via contracted transportation company and by the facility transport vehicle have the potential to be at risk of being moved by nurse aides after a fall without having an assessment by qualified personnel. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. As of 06/19/25, the facility will provide transportation services with our facility van unless the residents require stretcher service, then they are transported by EMS (ambulance service). The facility will continue with its current process of determining the appropriateness of wheelchair or stretcher transportation for residents. All residents who lack upper body strength and are unable to sit up in a wheelchair will be transported to appointment via stretcher. All appointments are discussed in the morning meeting daily for the next week with the Director of Nursing, Director of Rehabilitation and Administrator. Any resident identified at time requiring special accommodation for transport will have the change made for transportation. The care plan will be updated when the resident is identified as requiring stretcher transportation, for future reference. The facility van drivers, which included 2 alternate drivers (Maintenance Director and Admission Coordinator), were educated by the Director of Facility Services on 06/20/25, to notify a nurse or medical provider if a resident falls while being transported or calling 911 immediately via their personal cell phones. A reminder notice was placed in the transportation vehicle stating to "call 911 in case of an emergency." The education also included a nurse or medical provider must conduct a head-to-toe assessment of the resident prior to being moved. On 06/19/25, the Administrator in-serviced all department heads (Director of Rehabilitation, Food Service Manager, Environment Service Manager, Activities Director, Human Resources Director, Social Services, Director of Nursing, Business Office Manager, Staff Development Coordinator, MDS Coordinator and Admission Director) on notifying a nurse or medical provider immediately, if notified by the driver of a fall on the van.	F0684		

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F0684 SS = SQC-J	Continued from page 25 On 06/19/25 the Staff Development Coordinator, Director of Nursing, Activities Director and Human Resources Director conducted an in-service for all employees in person and via phone including agency personnel, on what to do if they witness a resident fall. Employees, including agency personnel, will not be allowed to complete a shift before completion of this training by the Director of Nursing, Staff Development Coordinator or designee. The Staff Development Coordinator, Director of Nursing and Administrator are responsible for ensuring all employees including agency personnel have completed the training. In addition, the orientation process was reviewed and reporting accidents and conducting an assessment prior to moving the resident will be part of the new hire orientation process. Alleged Date of IJ Removal: 06/20/25. The facility's IJ removal plan was validated on 06/24/25 by the following: Interviews with the facility transporters revealed they had received education on proper procedures if a resident was to have a fall, injury, or accident in the facility van 911 was to be called immediately, and staff were not to move resident until assessed by a medical professional. Staff would call the facility to notify them of the incident. The education was also included as a component of transportation orientation. The facility cancelled their contract with the Contract Transport Company on 06/19/25. Interviews were also conducted with alert and oriented residents who had been transported since 06/19/25 and no concerns or issues noted. Interviews with all staff revealed they had been educated on the facility fall protocol to include post fall procedures, making sure a resident was assessed by a licensed nurse or medical professional prior to moving the resident, calling 911 if needed, making sure residents received proper treatments for any injuries, notifying the facility if the accident or fall occurs outside of the facility or on the van, notifying the physician and the resident's responsible person, informing Administration if there are any issues or concerns pertaining to the accident or the fall, and notify supervisor or Administration with any changes in condition. The interview with the Administrator revealed she had	F0684		

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F0684 SS = SQC-J	Continued from page 26 educated all staff on fall protocols to include any fall, injury, or accident which occurred while transporting. The education included resident would be assessed by the licensed nurse or medical personnel prior to the resident being moved, calling 911 if needed, notifying the facility if the accident occurred during transport, notifying the physician, and resident would not be moved until assessed by licensed medical personnel, and making sure appropriate treatment was provided. The facility's immediate jeopardy removal date of 06/20/25 was validated. 2. Resident #15 was initially admitted to the facility on 11/27/19 and was readmitted to the facility on 01/03/25 with diagnoses that included: displaced intertrochanteric fracture of the right femur, subsequent encounter for closed fracture with routine healing, muscle wasting/atrophy multiple sites, and primary osteoarthritis. Resident #15's care plan was last updated on 11/08/24 as being at risk for falls related to confusion, gait/balance problems, psychoactive drug use, unaware of safety needs, wandering and history of falls and used a reclining chair, with interventions that included fall mat at bedside, anticipate resident's needs, and bed in lowest position while resident is in bed. Resident #15 was also care planned for pain related to arthritis and hepatic (liver) mass with interventions that included administer analgesics as ordered, monitor/document for signs and symptoms of nonverbal pain, monitor/report/record resident complaints of pain to the nurse. Resident #15 had an active physician's order dated 11/11/2024 for oxycodone-acetaminophen (pain medication) oral tablet 7.5-325 milligrams (mg) give one tablet by mouth two times a day for pain management. A quarterly Minimum Data Set (MDS) assessment dated 12/18/2024 revealed Resident #15 was moderately cognitively impaired. Review of a discharge MDS assessment dated 12/30/2024 indicated Resident #15 had a fall with major injury. Review of the progress note dated 12/28/2024 at 4:41pm, written by the Director of Nursing (DON) revealed the DON heard Resident #15 yelling and as the DON arrived	F0684		

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F0684 SS = SQC-J	Continued from page 27 at Resident #15's doorway the DON observed Resident #15 as she attempted to get out of bed. The DON was unable to reach Resident #15 before she fell onto her right side onto the fall mat. Resident #15 did not strike head but yelled out "my hip is broken". The DON assessed Resident #15, leg length could not be assessed due to mild contraction. Resident #15 expressed pain when area to right hip was touched. Facility Physician Assistant (PA) was contacted and orders received to obtain right hip x-ray and to give a one-time dose of oxycodone 2.5 mg related to acute right hip pain. The progress note indicates Resident #15 was assisted back to bed by staff x 3 and x-ray was pending. Review of Resident #15's orders revealed on 12/28/2024 at 4:25 PM the PA ordered oxycodone HCL 5mg tab- give 0.5 (half) tablet by mouth one time only for right hip pain x 1day. Review of Resident #15's orders revealed on 12/28/2024 at 4:32 PM the PA ordered an x-ray of Resident #15's right hip one time only for pain x 1 day. Review of the x-ray completed on 12/29/2024 with results reported to the facility on 12/29/2024 at 2:09 PM revealed Resident #15 sustained an acute right femoral intertrochanteric fracture. An interview with the DON on 6/20/2025 at 11:04 AM revealed she cared for Resident #15 on 12/28/2024 3:00 PM to 11:00 PM. The DON stated on 12/28/2024 she heard Resident #15 yelling for help and when she came to the door, Resident #15 was attempting to get out of bed and the DON was unable to reach Resident #15 in time, Resident #15 fell out of her bed, onto her right side. The DON stated Resident #15's bed was in the lowest position and Resident #15 had fallen onto her fall mat next to the bed. The DON stated Resident #15 yelled that her hip was broken. The DON stated she immediately assessed Resident #15. The DON stated due to Resident #15's legs being contracted it was difficult to assess the length of Resident #15's legs. The DON stated she called the facility PA to report the fall and received orders for a right hip x-ray and oxycodone 2.5 mg for pain. The DON stated after she received the orders from the PA, she and two staff members transferred Resident #15 back to her bed with a mechanical lift. The DON stated after being transferred back to bed and pain medication was administered, Resident #15 attempted to crawl out of the bed multiple times. The DON stated	F0684		

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F0684 SS = SQC-J	Continued from page 28 Resident #15 was then transferred using the mechanical lift into her reclining chair and placed next to the nurse's station. The DON verified when Resident #15 was placed in the reclining chair she was sitting up, unsure of the exact position, but stated it was probably 90 degrees because the reclining chair was not reclined. The DON stated that sitting at a 90 degree angle was not a good position to be in for a resident experiencing hip pain after a fall, but since Resident #15 was continuing to attempt to get up the DON felt it was the best option at that time. The DON verified she instructed the staff to get Resident #15 up into the reclining chair to prevent further falls. The DON stated Resident #15 had a history of yelling out and with her continued movement she did not think Resident #15 had sustained a fracture. The DON stated the PA had only given an order for the x-ray to be obtained, and did not specify it should be a stat (now) order. The DON stated that when Resident #15 was in her chair at the nurse ' s desk, Resident #15 responded she was not in pain when asked. The DON stated she called in the order for the right hip x-ray to the mobile x-ray service. The DON stated the x-ray was not called in stat. The DON stated a mobile x-ray order placed in the evening or on a weekend had the potential to not be completed until the next day. The DON stated she reported to the oncoming shift, Nurse #1, that an x-ray was ordered and was waiting to be completed for Resident #15. The DON stated that typically the mobile x-ray reports were automatically uploaded into the resident electronic medical record and any nurse with access to the medical record could review x-ray reports. If there was positive fracture results the mobile x-ray company would call and alert the facility. Once the facility was notified, she would expect the staff to immediately notify the provider for further orders. The DON added that she believed there was a delay in the facility receiving the x-ray report which also delayed Resident #15 in being transferred to Emergency Room (ER) for evaluation. During a telephone interview on 6/20/2025 at 12:12 PM Nurse #4, who was scheduled 11:00 PM to 7:00 AM on 12/28/2024 and 12/29/2025, stated he did not recall Resident #15 specifically or any information related to a fall. He stated he may have been scheduled to take care of Resident #15 but did not remember back that far. Review of Resident #15's Medication Administration Record (MAR) dated December 2024 revealed the following documentation:	F0684		

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F0684 SS = SQC-J	Continued from page 29 On 12/28/2024 at 6:55 PM oxycodone 2.5 mg was documented as administered by the DON for a pain level of 8 out of 10. On 12/28/2024 at 9:00 PM scheduled oxycodone-acetaminophen 7.5-325 mg was documented as administered by the DON. Pain assessments on 12/29/2024 revealed a documented pain level of 0 out of 10 on all 3 assessments. Pain assessment on 12/30/2024 revealed a documented pain level of 0 out of 10, for the shift 11:00 PM to 7:00 AM. Review of Resident #15's electronic medical record revealed no documentation regarding Resident # 15's right hip or x-ray in the progress notes that were dated 12/29/2024. Review of the 24-hour report sheets from 12/29/2024 indicated Resident #15 was status post fall day 1 and mobile x-ray company was coming 12/29/2024 in AM for right hip x-ray. Review of the x-ray results completed on 12/29/2024 at 1:19 PM revealed Resident #15 sustained an acute right femoral intertrochanteric fracture. Multiple attempts to reach Nurse #17, who worked with Resident #15 on 12/29/2024 from 7:00 AM to 3:00 PM were unsuccessful. Multiple attempts to reach Nurse #18 who worked with Resident #15 on 12/29/2024 from 3:00 PM to 11:00 PM were unsuccessful. During a telephone interview on 6/20/2025 at 4:35 PM Nurse #5 stated she was not at work when Resident #15 fell on 12/28/24 but worked on 12/30/24 and received	F0684		

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F0684 SS = SQC-J	Continued from page 30 the x-ray results. Nurse #5 stated she answered a call from the mobile x-ray company, who called to verify the facility had received the x-ray results for Resident #15. Nurse #5 stated after she received the call, she checked the electronic medical record for radiology results, saw that it indicated a fracture, printed the report and immediately brought it to the facility PA who reviewed the x-ray report and gave orders to send Resident #15 to the emergency room. Nurse #5 stated once she received the order from the PA she immediately called 911 for transport and started the process to send Resident #15 to the hospital. Review of Resident #15's electronic medical record revealed a Physician progress note dated 12/30/2024 at 1:16 PM written by a Nurse Practitioner (NP) that indicated Resident #15 had reported pain at a 10 out of 10 when she was assessed, but in no apparent distress, and no tenderness to palpation of bilateral upper and lower extremities, unable to test range of motion in the right lower extremity due to increased pain, and nursing reports she is being sent to the hospital for right hip fracture. During a telephone interview on 6/20/2025 at 12:56 PM the facility NP stated she had seen Resident #15 on the morning of 12/30/2024 as part of her rounds. Resident #15 complained repeatedly that her pain was 10 out of 10. The NP stated she was not aware of the hip fracture before she saw Resident #15 on 12/30/24. The NP stated after she saw Resident #15, she went to the nursing staff to report the resident's pain and was told Resident #15 was being sent to the hospital. The NP stated she would normally inform the facility PA but since she was informed the Resident was being sent out, she did not talk to the facility PA. Review of progress notes revealed a note dated 12/30/2024 at 9:29 AM written by Nurse #2 revealed x-ray results were received and reported to the facility PA and orders to send Resident #15 to the emergency room for further evaluation and treatment of right hip were received. Report was called to the hospital and Resident #15 was transferred to the hospital. Review of Resident #15's hospital records dated 12/30/24 revealed Resident #15 presented to the hospital on 12/30/2024 with a right intertrochanteric femoral fracture and underwent closed reduction and	F0684		

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F0684 SS = SQC-J	Continued from page 31 cephalomedullary (hardware used to fix broken bones) nail fixation. Documentation from hospital physician revealed Resident #15 was confused, voiced right hip pain, no painful response noted when right hip was palpated, and resident had active range of motion in bilateral lower extremities while in bed. During an interview on 6/20/2025 at 8:52 AM the Physician Assistant (PA) stated he had received a call from the DON regarding Resident #15 and a fall on 12/28/24. The PA stated he did not recall the DON reporting that Resident #15 yelled "my hip is broken", but that wound not have changed his mind regarding the order for the x-ray and not sending Resident #15 to the hospital on 12/28/2024. The PA stated Resident #15 was not a reliable historian. The PA stated he had received report Resident #15 did not have leg shortness. The PA stated normally an x-ray would take about 4 hours to be completed, but on evenings and weekends it sometimes took longer. The PA stated he was not aware that Resident #15 had been placed in the reclining chair prior to the x-ray being completed. The PA stated he would expect a resident to stay in bed until the x-ray had been done. The PA stated when he arrived at the facility on 12/30/2024 he was informed of Resident #15's x-ray results and immediately gave orders for Resident #15 to be sent to the hospital for an orthopedic evaluation. The PA stated they have on call providers on the weekend and ideally the x-ray results would have been received on 12/29/2024 and reported to him or the on-call provider and Resident #15 would have been sent to the hospital on 12/29/2024. During a telephone interview on 6/26/2025 at 11:23 AM the facility Physician stated x-ray reports were faxed to the facility and available in the resident ' s electronic medical record. The Physician stated all nurses would have access to review the x-ray results in the medical record and the fax would come in on the copy machine in the hallway. The Physician stated agency nurses may know to check the copy machine, but she would expect the nurses to answer the phone as soon as they were able and review the chart for results if an x-ray was pending. During a joint interview on 6/20/2025 at 4:35 PM with the Interim DON and Administrator, Interim DON stated she was not going to provide an answer to questions regarding the fall because she thought a loaded question had been asked and did not want to comment on an event she did not have all the details for. The	F0684		

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F0684 SS = SQC-J	Continued from page 32 Administrator stated she felt Resident #15 had received appropriate care after her fall on 12/28/2024. The Administrator stated after a fall she expected a nurse to assess the resident, notify the provider and report the findings from the assessment. The Administrator stated she felt the DON did what was appropriate to keep Resident #15 safe. The Administrator stated she would expect a resident with a fracture to be sent to the hospital once they were notified of the fracture.	F0684		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, resident, observation, staff, Physician Assistant (PA), Transport Company's Owner, and Driver #1 (Transport Company's Driver) interviews, the facility failed to ensure a resident was safely secured in the transport company's van during the return trip from an appointment back to the facility. On 3/26/25 Driver #1 failed to secure Resident #101 in a specialized wheelchair in the Transport Company's van per manufacturer's instructions and according to Driver #1 when the van hit a "bump" pulling into facility entrance, Resident #101 fell forward, landing partially out of her wheelchair with her legs under the chair. Resident #101 was assisted back into the wheelchair by facility staff at the facility and was wheeled inside the facility. After being assessed by the nurse, Resident #101 was transported to the Emergency Department (ED) on 03/26/25, evaluated for injury, and then returned to the facility on 03/26/25 with no injury noted upon assessment at the ED. There was a high likelihood of serious injury, or death, to Resident #101 due to the resident being an unsecured passenger in a specialized wheelchair which was not designed for transportation as she was transported back to the facility from an appointment. The facility also failed to provide effective supervision to prevent a resident-to-resident altercation when Resident #76 hit	F0689	-689 Immediate Jeopardy Removal Plan Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and On 03/26/25, Resident #101 was picked up by contract transportation contracted Driver #1 from a scheduled dialysis appointment for transport back to the facility. Prior to leaving the appointment, the contract driver secured Resident #101's Broda wheelchair to the vehicle but failed to secure Resident #101 to the vehicle. The construction of the Broda chair prevented a snug restraint around Resident #101 and did not stop Resident #101 from falling forward in the chair. Resident #101 had a high likelihood of suffering an adverse outcome related to not being secured to the vehicle to prevent them from falling out of the chair onto the footrest and using a chair not designed for transport in a vehicle. All residents in any type of wheelchair are at risk of an adverse outcome while being transported if the wheelchair used is not secured to the vehicle in compliance with the restraint manufacturer and if they are not in a wheelchair designed for transport. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. All staff and agency staff were in-serviced on 6/20/2025 by the Director of Nursing, Staff Development Coordinator and Human Resources on identifying safe wheelchairs to be used during transportation. This education included that any patient in a Broda wheelchair will be transported by non-emergent ambulance services or in a facility designated transport wheelchair that is designed for vehicle transportation. This education also included the removal of additional objects from the wheelchair that	07/22/2025

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F0689 SS = SQC-J	Continued from page 33 Resident #58 in the lip when Resident #76 attempted to grab the television remote from Resident #58. When Resident #58 grabbed the remote back, Resident #76 hit Resident #58 on the lip. Resident #58 had a small bruise on top of his left hand, but no visible injury to lip or face. This deficient practice affected 2 of 7 residents reviewed for abuse (Resident #101 and Resident #58). Example #2 was cited at a scope and severity of D. Immediate Jeopardy began on 03/26/25 when Resident #101 was improperly secured in the wheelchair van and slid out of her wheelchair on the transportation company's van while being transported back to the facility from a scheduled appointment. The immediate jeopardy was removed on 06/20/25 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a D (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. The findings included: 1. A review of the Transport Company's van vehicle anchorage and accessory manufacturer instructions indicated wheelchairs would be anchored to the van using a retractable 4-point anchor tie-down system. Two anchors would be applied to the front base of the wheelchair and two would be attached to the back base of the wheelchair. A detachable lap belt would fasten to the floor anchor system, and chest belt would then be anchored to the side and behind the resident and applied for all wheelchair-bound residents during transport. A review of the Transport Company and facility contract dated 08/24/12 revealed the Transport Company would provide "safe transit" which was defined as "transporting patients to required destinations without scare or endangerment." Resident #101 was initially admitted to the facility on 02/20/24 and was readmitted to facility on 05/13/25. Resident #101's diagnoses include end-stage kidney disease, encephalopathy (brain disease which caused	F0689	Continued from page 33 might be placed inappropriately and interfere with the ability to apply the restraint as designed. The contract was cancelled on 6/19/2025 for the outside transportation company used during the adverse incident. We will only use our in-house transportation vehicle except for stretcher services. All residents requiring a Broda chair for transport will be transported by EMS stretcher service until a chair designed for vehicle transportation has been obtained. The in-house transportation driver and all designated back up drivers were in-serviced on 6/20/2025 by the Regional Maintenance Director. This in-service included how to secure residents according to manufacturer's instructions during wheelchair transportation. The manufacturer's manual and restraint system manual were referenced for this training. A return demonstration by all individuals trained was performed as well. How facility will monitor its performance to make sure that solutions are sustained: The Maintenance Director or Designee will audit 3 resident transport for securement and proper chair for transport weekly for 4 weeks, 3 resident transport biweekly for 2 weeks, and then monthly for one month. Findings from these audits will be reviewed at the monthly Quality Assurance meeting for 3 months minimum. The administrator is responsible for implementing the acceptable Plan of Correction. The date of immediate jeopardy removal is 6/21/2025. Date of compliance 7/22/2025 F689 The statements included are not admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance with state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the date indicated. Corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F0689 SS = SQC-J	Continued from page 34 confusion), cerebral infarction (stroke), muscle weakness, and limited mobility. A review of Resident #101's physician orders revealed an order dated 11/04/24 for apixaban (blood thinner) 5 milligrams by mouth twice daily; and an order dated 12/11/24 for hemodialysis every Monday, Wednesday, and Friday at 11:30 AM at the local dialysis center. A review of the annual Minimum Data Set (MDS) dated 01/21/25 revealed Resident #101 was severely cognitively impaired. Resident #101 utilized a specialized wheelchair for mobility, a mechanical lift for all transfers, and had impairments to both upper and lower extremities with contractures. The MDS also noted Resident #101 received an anticoagulant (blood thinner) and dialysis. The care plan originally initiated 02/20/24 included the problem for Resident #101 of the resident being at risk for falls due to deconditioning. The stated goal was the resident would be free from falls. The listed interventions included anticipating the resident's needs, staff would ensure the call device was in place, and staff would provide reminders for the resident in fall prevention. A review of Driver #1's undated statement revealed he picked up Resident #101 after her dialysis treatment and secured Resident #101 into her specialized wheelchair inside the transport van using the 4-point anchor system. Driver #1 indicated he also secured Resident #101's seatbelt "Under her arms and snug around her midsection." Driver #1's statement further revealed when he pulled into the facility entrance, he noticed Resident #101 had "slid out from under her seatbelt and was sliding out of her chair." Driver #1 entered the facility and requested staff assistance. The statement revealed Driver #1 observed [name redacted (NA#1)] and [name redacted (NA #2)] lift Resident #101 back into her wheelchair. Driver #1 reported one of the NA's stated Resident #101 "needed a belt to better keep her in her chair" as Resident #101 cannot sit up. Driver #1 left after Resident #101 was taken back into the facility. A phone interview was attempted with Driver #1, but he was unable to be reached.	F0689	Continued from page 34 On 5/27/2025 Resident #58 and Resident #76 was witnessed by therapy staff #1 to have a physical altercation when Resident # 76 came into the room and took the remote from Resident #58 hand. Resident #76 hit Resident #58. No injury noted to Resident #58. Resident #76 was moved to another room on another unit on 5/27/2025. Facility failed to place a second television in resident #76 new room timely. No further incidents noted. Identification of residents having the potential to be affected by the same deficient practice: No other resident was identified to be affected by this same deficient practice. Television was placed in resident #76 room on 6/20/2025 by the Maintenance Director. On 6/25/2025 the Facility Administrator completed an audit on the last 30 days reportable resident altercations to ensure interventions were implemented timely. On 7/17/2025 the Facility Administrator in-serviced the management team on follow through with resident interventions timely and the importance on follow through to aid in prevention of further incidents. Measures / systemic changes made to ensure that the deficient practice will not recur: On 5/27/2025, the Director of Nursing and Staff Development Coordinator initiated in-services to all staff including clinical personnel regarding providing adequate supervision, Abuse, Neglect, and Exploitation education which included Protection of Resident, Revision of the resident's care plan. This education was completed on 5/30/2025. All staff including agency clinical personnel who have not received this education by 5/30/2025 will not be allowed to work until this training has been completed prior to the start of their shift. This education will be included in the new hire and agency orientation process for all clinical personnel to ensure compliance. Resident to resident altercations will be reviewed weekly at the Clinical Meeting with the Facility Administrator, the Director of Nursing, Unit Mangers, Social Services and Rehab Director Monday thru Friday. Any further recommendations from this meeting will be added to the individual residents' care plan.	

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F0689 SS = SQC-J	Continued from page 35 A review of nursing progress note dated 03/26/25 written by Nurse #1 revealed the NA reported to Nurse #1 Resident #101 was on the floor of the transport van. Review of a facility incident report dated 03/26/25 completed by Nurse #1 documented the Nursing Assistant (NA) reported Resident #101 was on the floor of the transport van. Driver #1 reported Resident #101 slid from chair in a curve. No injuries were noted upon nurse assessment by Nurse #1. The physician and responsible party were notified. Resident #101 was transferred to the ED for evaluation after the incident on 03/26/25. A review of NA #1's undated written statement revealed at 4:45 PM, NA #2 asked NA #1 to assist Resident #101 in the transport van after a fall. The statement revealed Driver #1 explained to them (NA #1 and NA #2) Resident #101 was "adjusting herself during car ride and while pulling into the parking lot, she slid out into van floor." The statement revealed NA #1 observed Resident #101 lying on the floor of the van on her right side with her legs bent against the back of driver's seat and her back was on the footrest of the wheelchair. It was noted the seatbelt was around Resident #101's wheelchair. An interview with NA #1 on 06/19/25 at 3:23 PM revealed she recalled NA #2 had requested her help on the transport van because Resident #101 had fallen. NA#1 stated, she observed Resident #101 on the floor of the van when she arrived to assist. NA #1 indicated Driver #1 told them Resident #101 had been fidgeting and when he pulled into the facility driveway, he hit a bump and Resident #101 slid out of her chair. NA #1 reported Resident #101's back rested on the wheelchair footrest, which was extended out, and both of Resident #101's legs were on the floor under the footrest of her wheelchair. NA #1 reported the seat belt was fastened and rested on the back seat area of the wheelchair. NA #1 stated it appeared Resident #101 had slid under the seatbelt. NA #1 also stated Resident #101 had asked to get up off the van floor and denied any pain. NA #1 revealed once Resident #101 was back into her wheelchair, NA #1 left and returned to her assigned hall. A review of NA #2's written statement dated 03/26/25 revealed staff had asked her to assist getting Resident	F0689	Continued from page 35 Facility plans to monitor performance to make sure solutions are sustained: The Facility Administrator or Designee will conduct audits of resident-to-resident altercations weekly x 8 then monthly x 2 months, to ensure resident altercation interventions are followed. The Facility Administrator will present the findings of these audits to the QAPI committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained ongoing, and determine the need for further monitoring. Date of compliance 7/22/2025	

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DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD , NEBO, North Carolina, 28761

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F0689 SS = SQC-J	Continued from page 36 #101 off of the transport van when Driver #1 notified staff Resident #101 fell. NA #2 saw NA #1 and asked for her help and they both went to the transport van. NA #2 wrote she observed Resident #101 "out of her chair, legs folded up under her, leaning to the right side." She reported she asked Resident #101 if she was ok or if anything hurt, and Resident #101 responded "no." An interview with NA #2 on 06/19/25 at 3:35 PM revealed NA #2 had walked by the main entrance when Driver #1 told the front desk staff Resident #101 fell on the transport van and needed help. NA #2 observed Resident #101 on the van with the buckled seatbelt around her breasts and she had slid down under the seatbelt. NA #2 stated Resident #101 was seated on the wheelchair footrest with both of her legs positioned under the chair footrest. Review of the hospital discharge summary dated 03/26/25 revealed Resident #101 was transferred via Emergency Medical Services (EMS) to be evaluated after fall. It was noted in the hospital discharge summary Resident #101 received an anticoagulant. The hospital record stated Resident #101 had no signs of acute injury upon assessment and had no complaints of pain during examination. A computed tomography (CT) of Resident #101's head, thoracic (middle) spine, and lumbar (lower) spine were completed and results indicated no acute injury was noted on the CT. No acute injuries were reported. No new orders were received and Resident #101 returned to facility on 03/26/25 via EMS. A review of the facility transport van vehicle anchorage and accessory manufacturer instructions, which were a different system than what was used in the transport company van, indicated wheelchairs would be anchored to the van using retractable 4-point anchor tie-down system. Two anchors would be applied to the front base of the wheelchair and two would be attached to the back base of the wheelchair. A detachable lap belt would fasten to the floor anchor system, and chest belt would then be anchored to the side and behind the resident and applied for all wheelchair-bound residents during transport. An interview with Driver #2, who was employed by the facility, on 06/19/25 at 10:50 AM revealed Resident #101 was transferred to her dialysis appointments on Monday, Wednesday, and Friday. Driver #2 reported Resident #101 used a specialized reclining wheelchair	F0689		

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F0689 SS = SQC-J	Continued from page 37 during transport. Driver #2 indicated Resident #101 was placed in a high-reclined position, while still upright during transport for resident comfort. The facility transport van had 4 detachable floor anchors that hooked to the wheelchair base which secured the wheelchair to the van. Driver #2 reported the seatbelt was placed over Resident #101's wheelchair armrest because there were no open areas on the armrest of the wheelchair to loop the lap belt through. Driver #2 indicated there was a shoulder strap attached to the lap belt, but since Resident #101 was in the reclined wheelchair, it was often not tight. Driver #2 reported Resident #101 preferred the seat belt loose around her abdomen for comfort. An observation was conducted on 06/19/25 at 1:18 PM of Driver #2 loading Resident #101 into facility transport van, not the transport company van, for a medical appointment. The observation revealed a detachable 4-point wheelchair securement system on transport van in place. Resident #101's specialized wheelchair wheels were locked, and the wheelchair was anchored using a 4-point wheelchair securement system and appeared secure. Observation of application of the lap belt revealed a removable pelvic belt which attached to the floor anchor. The pelvic belt was applied over Resident #101's lap on top of the arm rest of her wheelchair. Resident #101 was reclined slightly in the wheelchair. The detachable shoulder strap was then applied but did not contact Resident #101's body and did not cross her shoulder and chest. During observation, Driver #2 stated Resident #101's wheelchair only allowed the lap belt to go over the wheelchair armrests due to no opening on the side of the armrests. She stated the detachable shoulder strap was positioned loosely due to the type of wheelchair Resident #101 had, but Driver #2 stated she felt Resident was secured. She asked Resident #101 if the belt bothered her to which Resident #101 responded "no." An observation and interview with Resident #101 on 06/16/25 revealed she was alert sitting in her specialized wheelchair after her dialysis appointment but was not able to be interviewed due to cognitive loss. An observation of the driveway was performed on 06/19/25 which revealed two entrances to the facility's main entry from the road the facility was on. The first entrance had an inclined curve that led into the parking lot. The second entrance had a short, steeper	F0689		

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F0689 SS = SQC-J	Continued from page 38 hill which turned sharply to the left into the parking lot. No discernable speed humps, holes, or bumpy areas were noted. It could not be determined which entrance Driver #1 entered the facility through on 03/26/25. Telephone interviews with the Transport Company Owner on 06/19/25 at 12:53 PM and 2:44 PM revealed he did recall the incident on 03/26/25 but could not recall who the driver was during the first interview but would check his records. He stated he had no written records of the incident but remembered what the driver told him. He stated Driver #1 told him Resident #101 had not fallen out of her chair, but her buttocks had come out a little forward in her wheelchair when Driver #1 hit a bump pulling into the facility driveway. The Transport Company owner reported Driver #1 parked the transport van, and Resident #101 was on the edge of her wheelchair seat and her seatbelt still held her in place in the wheelchair. Driver #1 reported to Transport Company Owner Driver #1 unlatched Resident #101's seatbelt and lowered the resident to the floor. Driver #1 entered the facility and told the staff who helped get Resident #101 up. During the second interview, the Transport Company Owner stated Driver #1 resigned from the company 6 weeks ago and no longer worked for them. The Transport Company Owner stated he voiced concerns to the facility about the chair for Resident #101 and felt it was unsafe. The Owner stated he had not documented this on an incident report, but he spoke with Driver #2 about his concerns. He stated he had recommended a stretcher chair which he had available for use, but the facility would not use it. He reported there were several incidents where Resident #101 would slide down in her wheelchair, and he notified the facility when that occurred, but he stated there was no record of that. He reported after that episode on 03/26/25, he refused to transport Resident #101 due to his safety concerns. He indicated he believed there was no way to place the belt on her wheelchair according to the manufacturer's instructions, thus his company could not transport her safely. An interview with the facility PA on 06/20/25 at 10:08 AM revealed Resident #101 was totally dependent on staff for all activities of daily living. The PA stated Resident #101 was severely cognitively impaired. PA indicated Resident #101 had very limited mobility due to upper and lower body contractures. PA reported Resident #101 was unable to do anything to brace herself or prevent a fall. Resident #101 received an anticoagulant (blood thinner) and thus would be at risk	F0689		

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F0689 SS = SQC-J	Continued from page 39 of bleeding with any fall or accident. Due to the use of an anticoagulant, bleeding could occur anywhere in the body. Regarding a fall when Resident #101 was on an anticoagulant, the PA would be most concerned about the possibility of a head injury with bleeding on or around the brain which would be life threatening. The interview with the Administrator on 06/19/25 at 4:15 PM revealed after the incident, she had interviewed Driver #1 who stated he had hit a bump pulling into the facility driveway and Resident #101 had slid out of her wheelchair. The Administrator indicated the transport company owner would not cooperate with the investigation and would not initially provide a statement or records of training the company provided Driver #1, but did eventually provide a written statement to the facility from Driver #1. The Administrator indicated the transport company owner never spoke to her prior to this incident about any concerns related to the safety of Resident #101's wheelchair. After the incident, the transport company owner sent an email dated 04/03/25 to the Administrator that the company had a stretcher chair available for use beginning 04/01/25. Information on the stretcher chair was included in the email. The Administrator reported the stretcher chair the transport company owner recommended had built in restraints that they were not allowed to use. The Administrator recalled at that time; the decision was made to transport Resident #101 by facility van only and no longer use the Transportation Company for Resident #101. The Administrator indicated Resident #101 had never been evaluated by therapy for transport chair needs, but a non-skid mat was added to wheelchair after the incident. The Administrator further stated Resident #101 continued to be transported by the same specialized wheelchair that was used during the 03/26/25 fall. The facility was notified of immediate jeopardy on 06/19/25 at 7:35 PM. The facility provided the following plan for IJ removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance	F0689		

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F0689 SS = SQC-J	Continued from page 40 On 03/26/25, Resident #101 was picked up by contract transportation Contracted Driver from a scheduled dialysis appointment for transport back to the facility. Prior to leaving the appointment, Driver #1 secured Resident #101's specialized wheelchair to the vehicle but failed to secure Resident #101 to the vehicle. The construction of the specialized chair prevented a snug restraint around Resident #101 and did not stop Resident #101 from falling forward in the chair. Resident #101 had a high likelihood of suffering an adverse outcome related to not being secured to the vehicle to prevent them from falling out of the chair onto the footrest and using a chair not designed for transport in a vehicle. All residents in any type of wheelchair are at risk of an adverse outcome while being transported if the wheelchair used is not secured to the vehicle in compliance with the restraint manufacturer and if they are not in a wheelchair designed for transport. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. All staff and agency staff were in-serviced on 06/20/2025 by the Director of Nursing, Staff Development Coordinator and Human Resources on identifying safe wheelchairs to be used during transportation. This education included that any patient in a specialized wheelchair will be transported by non-emergent ambulance services or in a facility designated transport wheelchair that is designed for vehicle transportation. This education also included the removal of additional objects from the wheelchair that might be placed inappropriately and interfere with the ability to apply the restraint as designed. The contract was cancelled on 06/19/2025 for the outside transportation company used during the adverse incident. We will only use our in-house transportation vehicle except for stretcher services. All residents requiring a specialized chair for transport will be transported by EMS stretcher service until a chair designed for vehicle transportation has been obtained.	F0689		

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F0689 SS = SQC-J	Continued from page 41 The in-house transportation driver and all designated back up drivers were in-serviced on 06/20/2025 by the Regional Maintenance Director. This in-service included how to secure residents according to manufacturer's instructions during wheelchair transportation. The manufacturer's manual and restraint system manual were referenced for this training. A return demonstration by all individuals trained was performed as well. Alleged Date of IJ Removal: 06/21/25. The facility's IJ removal plan was validated on 06/21/25 by the following: Interviews with the facility transporters revealed they had received education on restraint system in van and how to secure a resident in the van per manufacturer's instructions, as well as the transport securement form that was to be completed prior to leaving facility with residents. The facility transporters also stated they had to verbalize their understanding of the education they had received and complete a demonstration showing they were capable of securing residents per manufacturer's instructions inside the van for transport. The facility transporters revealed they would only transport residents in standard wheelchairs inside the facility vans at this time and any resident that required a different type of chair for transport would have to be transported by non-emergent EMS transport. The facility cancelled their contract with the Transport Company on 06/19/25. Review of facility orientation education for new hire transport drivers verified the education included the transport securement form and educational material on van restraint system and securing residents per manufacturer's instructions into van prior to transport. Review of the audit tools and the transport securement form was completed with no issues noted. An observation was made on 06/20/25 of the facility transport driver securing a resident into their wheelchair inside the van in accordance with the manufacturer's instructions prior to being transported. Interviews were also conducted with alert and oriented residents who had been transported since 06/20/25 with no concerns and no additional transportation incidents were identified. Interviews with all staff revealed they had been educated on the correct chair to use for resident transport and if a resident required a specialized chair they could only be transported by non-emergent transport via Emergency Medical Services (EMS), making sure all residents are restrained per manufacturer's instructions in their transport chairs, remove any items from transport chairs that might	F0689		

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F0689 SS = SQC-J	Continued from page 42 interfere with the residents ability to be restrained per manufacturer's instructions, and notify administration immediately if there are any issues or concerns with a resident's transport chair. An interview with the Administrator revealed she had educated the facility transport drivers on securing residents per manufacturer's instructions into the vans, completing the transport securement form, hands-on observations of drivers securing residents into vans prior to transport, and completed audits with no issues. The Administrator also stated the facility had ordered an approved transport wheelchair but until that chair was delivered, they would only transport residents with standard wheelchairs in their facility vans and residents who required a transport wheelchair would be transported by non-emergent EMS transport. The facility's immediate jeopardy removal date was validated as 06/21/25 and the IJ removal plan completion date was validated as 06/21/25. 2. Resident #76 was admitted to the facility on 07/25/24 with diagnoses which included unspecified dementia, cerebrovascular disease, and chronic obstructive pulmonary disease (COPD). The quarterly Minimum Data Set (MDS) dated 03/10/25 revealed Resident #76 was severely cognitively impaired, had no impairment of range of motion to upper or lower extremities, and used a wheelchair for mobility. Resident #76 required moderate assistance with transfers and could propel himself in a wheelchair. A review of Resident #76's care plan noted a plan in place for behavior problems due to resistance to care, yelled at staff, verbally aggressed to roommates, and refused medications at times. The stated goal for the care plan was Resident #76 would have fewer episodes of behavior. Interventions included administering medications, explaining procedures to Resident #76 prior to care, discussing appropriateness of behaviors, and intervening to prevent injury to others. A second care plan in place noted Resident #76 had a mood problem. The stated goal was Resident #76 would demonstrate improved mood state. Interventions included administering medications as ordered. A third care plan is in place for impaired cognition related to dementia. The stated goal for the care plan is Resident #76 would be able to communicate his needs. Interventions include staff to have appropriate communication with Resident #76.	F0689		

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F0689 SS = SQC-J	Continued from page 43 Resident #58 was admitted to the facility on 09/10/24 with diagnoses that included cognitive communication deficit, generalized anxiety disorder, unspecified osteoarthritis, and major depressive disorder. The annual MDS dated 06/04/25 revealed Resident #58 was cognitively intact. No behaviors were noted on lookback period. Resident #58 used a wheelchair for mobility and both legs were amputated above the knee. MDS noted Resident #58 had no impairment of range of motion to his upper extremities. The care plan for Resident #58 dated 02/22/25 included a care plan for assistance with activities of daily living (ADL) due to amputation of both legs above the knee, and weakness. The stated goal was Resident #58 would be free from a decline in ADL. Interventions included assist Resident #58 with ADL as needed, allow rest, break up tasks into smaller steps, encourage self-care, and observe for changes in ADL and notify the nurse. A review of the initial allegation report completed by the Director of Nursing (DON) for an incident which occurred on 05/27/25 at 1:30 PM. Resident #58 was hit in the face near the lip area by Resident #76. Resident #58 was noted to have a small bruise on the top of his left hand, but no visible injury to lip or face. Resident #76 was noted to have a skin tear to the inside of his left forearm. Resident #76 and Resident #58 were separated by staff immediately and assessed for injuries. Resident #76 agreed to a room change, and his room was changed that day. The DON notified local law enforcement and the Department of Adult Protective Services. The report was signed by the DON on 05/27/25. The completed initial allegation report was faxed to the Division of Health Service Regulation on 05/27/25 at 3:11 PM. A review of the investigation report completed by the DON about the incident which occurred on 05/27/25 at 1:30 PM. Resident #58 was hit in the face near the lip area by Resident #76. Resident #58 was noted to have a small bruise on the top of his left hand, but no visible injury to lip or face. Resident #76 was noted to have a skin tear to the inside of his left forearm. Resident #76 and Resident #58 were separated by staff immediately and assessed for injuries. Resident #76	F0689		

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F0689 SS = SQC-J	Continued from page 44 agreed to a room change, and he was moved that day. The DON notified local law enforcement and the Department of Adult Protective Services on 05/27/25. Corrective actions included Resident #76 room change and corporate maintenance were contacted to provide 2 televisions per room to prevent future altercations. The investigation end date was signed by the DON as 06/02/25. The completed investigation report was faxed to the Division of Health Service Regulation on 06/02/25 at 7:51 PM. An interview with Therapy Staff #1 on 06/19/25 at 1:38 PM revealed she had walked down the hallway towards another resident's room when she heard Resident #58 and Resident #76 yelling at each other from their shared room. She entered the room and observed Resident #76 sitting in his wheelchair beside his bed and Resident #58 was also seated in his wheelchair facing Resident #76 who held the remote. Resident #58 reported to Therapy Staff #1 he had been watching television when Resident #76 grabbed the remote from him and changed the channel. Therapy Staff #1 reported she immediately separated the Residents. Therapy Staff #1 indicated after Residents were separated, she notified the nurse on the hall but could not recall the name of the nurse who was notified. Therapy Staff #1 indicated she did not observe any obvious injury on either Resident. An interview with the Infection Preventionist on 06/19/25 at 1:47 PM revealed she was notified of altercation between Resident #58 and Resident #76 by Therapy Staff #1. Therapy Staff #1 reported to Infection Preventionist Resident #58 and Resident #76 were heard fighting in their shared room. Therapy Staff #1 indicated to the Infection Preventionist that she had immediately separated the Residents. The Infection Preventionist stated she went to Resident #58 and Resident #76's room to assess both residents. Resident #58 stated to Infection Preventionist that Resident #76 took the television remote and changed the channel while Resident #58 was watching the television. Resident #58 further explained when he tried to grab the remote back from Resident #76, Resident #76 hit him (Resident #58) in the face. Upon assessment, Resident #58 had no injury noted to his lip or face, but a small bruise was noted on his left hand. The Infection Preventionist indicated Resident #76 could be confused and had changed rooms prior to this incident for not getting along with his roommates. The Infection Preventionist stated she was not aware of any other incidents of Resident #76 assaulting others.	F0689		

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F0689 SS = SQC-J	Continued from page 45 A progress note for Resident #58 dated 05/27/25 at 2:50 PM completed by Infection Preventionist stated Therapy Staff #1 observed Resident #58 and Resident #76 "fighting over the television remote." Therapy Staff #1 was able to separate them, and Resident #58 explained he was watching television when Resident #76 came in and took the remote and changed the channel. Resident #58 reported to staff Resident #76 "hit him in the face." No injury for Resident #58 noted upon physical assessment. The facility provider was notified of the incident. An additional progress note for Resident #76 dated 05/27/25 at 3:07 PM also completed by the Infection Preventionist stated Resident #58 and Resident #76 were fighting over the television remote. The residents were able to be separated by Therapy Staff #1. The note indicated Resident #58 accused Resident #76 of stealing the remote and changing the channel. Resident #58 also reported to staff Resident #76 hit him in the face. Resident #58 denied hitting Resident #76 back. Resident #58 and Resident #76 were separated. An observation and interview with Resident #58 on 06/16/25 at 11:38 AM revealed him to be alert, sitting upright in his wheelchair in his room watching television. He verbalized he recalled the altercation which occurred on 05/27/25 and reported Resident #76 grabbed the television remote when he was watching something and changed the channel. When Resident #58 attempted to grab the remote back from Resident #76, Resident #76 struck him on the lip. Resident #58 stated he had no injury from the altercation and denied physical pain. He reported he felt safe after Resident #76 was moved to another room, but he tried to avoid him when out of room. An observation and interview with Resident #76 on 06/17/25 at 11:15 AM noted he was alert, sitting upright in his wheelchair in his room. Resident #76 stated he recalled the altercation which occurred with Resident #58 on 05/27/25. He reported Resident #58 would not let him watch what he wanted so he grabbed the remote and hit Resident #58. Resident #76 further stated he did not get hurt and he agreed to move the same day. Resident #76 indicated he had no problems with his current roommate or sharing the television. An interview with the Director of Nursing (DON) on	F0689		

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F0689 SS = SQC-J	Continued from page 46 06/19/25 at 1:55 PM, who reported the Infection Preventionist notified her Resident #58 and Resident #76 were fighting over the television remote. The DON reported she completed an assessment of both Residents on 05/27/25 after the altercation. She indicated Resident #76 had reopened a skin tear on his left forearm which required no treatment; and Resident #58 did not sustain any visible injury to his lip or face but had a small bruise on his left hand. The DON stated Resident #76 agreed to a room change the same day. An interview with the Administrator and Corporate Nurse on 06/20/25 at 11:44 AM revealed the Administrator was on vacation when the altercation occurred and was not aware of it until she returned. The Administrator verbalized the corrective plan was to purchase new televisions but would require corporate maintenance approval, which takes time. The Administrator revealed Resident #76 was moved and was now in a room with a Resident who was not interested in watching television so Resident #76 would have more control over the remote. The Corporate Nurse reported they did not place a rush on the television order because Administration was not concerned about Resident #76 aggressing toward his new roommate.	F0689		
F0695 SS = E	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: m. Resident #31 was initially admitted on 11/10/20 with diagnoses that included chronic obstructive pulmonary disease (COPD), and chronic respiratory failure with hypoxia (low oxygen levels). Resident #31's physician orders revealed an order dated 01/16/24 for oxygen via nasal cannula continuously at 2 liters per minute.	F0695	F695 Respiratory/Tracheostomy Care and Suctioning The facility failed to post cautionary and safety signs that indicated the use of oxygen on door/door frame for resident #78, #90, #45, #32, #4, #10, #27, #61, #3, #36, #26, #57, and #67. Cautionary signs were ordered on 6/26/2025 and will be placed on those patients identified here. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents with oxygen are at risk. Maintenance Director/designee completed 100% audit of residents with cautionary and safety signs that indicate use of oxygen on resident door/door frame. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed floor nurses employed at Deer Park Health and Rehab will be educated by the Interim Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on cautionary and safety signs that indicate oxygen to be placed on resident's door/door frame. This education	07/22/2025

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F0695 SS = E	Continued from page 47 A review of Resident #31's care plan revised on 03/24/25 revealed a plan for oxygen therapy to relieve hypoxia due to COPD. The stated goal was that Resident #31 would have no signs of poor oxygen absorption. Interventions included oxygen via nasal cannula as ordered, monitor for signs of respiratory distress and notify provider if indicated, administer medications as ordered. Resident #31's significant change Minimum Data Set (MDS) dated 06/01/25 revealed that Resident #31 was severely cognitively impaired, dependent on staff for all activities of daily living, and coded for COPD, respiratory failure, and continuous oxygen use. An observation of Resident #31 on 06/16/25 at 12:18 PM revealed oxygen via nasal cannula in place and oxygen concentrator was in use at 2 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #31's room indicating oxygen in use. A second observation of Resident #31 on 06/1/25 at 2:40 PM revealed the oxygen concentrator administering oxygen to the resident at 2 liters per minute via the oxygen cannula in place. There was no cautionary oxygen in use signage outside of Resident #31's room indicating oxygen in use. During an interview with Nurse #12 on 06/18/25 at 8:14 AM stated Resident #31 received oxygen continuously. Nurse #12 stated that she did not know who was responsible for applying the oxygen in use cautionary signs to resident rooms. Nurse #12 indicated that she had not noticed that Resident #31 did not have a sign on his door. An interview was conducted with the Director of Nursing on 6/18/25 at 3:05 PM indicated safety signage for the use of oxygen should be posted outside the doors of residents' rooms that were using oxygen. The DON explained the staff member who brought the concentrator into the resident's room were responsible to hang the oxygen in use signs but it was ultimately all staff members' responsibility to make sure the oxygen in use signs were in place. An interview was conducted with the Administrator on 6/20/25 at 3:15 PM indicated she had not noticed there	F0695	Continued from page 47 will be completed by 7/22/2025. Licensed floor nursing staff not receiving education regarding the use of cautionary and safety signs that indicate oxygen use on resident door/door frame will not be allowed to work until education is received. New licensed floor nursing staff will receive the use of cautionary and safety signs that indicate oxygen use on resident door/doorframe within the orientation process by the staff development coordinator or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, SDC, or designee will audit residents with oxygen that cautionary/safety signs that indicate oxygen use is on door/door frame. 5 x weekly x 4 weeks, 3 x weekly x 4weeks, monthly x 3. The findings will be reviewed at the quarterly QAPI meetings to review progress. Date of compliance is 7/22/2025 The Administrator is responsible for implementing the acceptable plan of correction.	

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F0695 SS = E	Continued from page 48 were no oxygen in use safety signage posted on the doors of the residents' rooms who were prescribed oxygen. The Administrator stated oxygen in use signs should be posted on all doors of rooms where oxygen was being used, and she felt staff should know this. Based on observations, record review and staff interviews the facility failed to post cautionary and safety signage outside of resident rooms that indicated the use of oxygen for 13 of 36 residents reviewed for respiratory care (Resident #78, #90, #45, #32, #4,#10, #27, #61, #3, #36, #26, #57, #67). The findings included: a. Resident #78 was admitted to the facility on 5/2/25. A review of Resident #78's physician orders revealed an order dated 5/5/25 for oxygen to be administered continuously via nasal cannula at 4 liters per minute (l/min). A review of the quarterly Minimum Data Set (MDS) dated 5/8/25 indicated Resident # 78 was coded for receiving oxygen during the assessment period. An observation on 6/18/25 at 2:03 PM revealed Resident #78 was lying in bed wearing a nasal cannula with oxygen being administered at 4 l/min. There was no cautionary or safety signage posted at the entrance to Resident #78's room to indicate oxygen was in use. An observation of Resident #78 conducted on 6/19/25 at 11:00 AM revealed he was sitting on the side of his bed with oxygen being administered via nasal cannula at 4 l/min. There was no safety signage posted at the entrance to Resident #1's room to indicate oxygen was in use. b. Resident #90 was admitted to the facility on 12/13/23. A review of Resident #90's physician orders revealed an order dated 6/24/24 for oxygen to be administered via nasal cannula at 2 l/min as needed.	F0695		

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F0695 SS = E	Continued from page 49 A review of the quarterly MDS dated 4/27/25 indicated Resident #90 was coded for receiving oxygen therapy during the assessment period. An observation on 6/18/25 at 2:05 PM revealed Resident #90 was sitting in bed wearing a nasal cannula with oxygen being administered at 2 l/min. There was no cautionary or safety signage posted at the entrance to Resident #90's room to indicate oxygen was in use. An observation on 6/19/25 at 9:45 AM revealed Resident #90 was lying in bed and wearing a nasal cannula with oxygen being administered at 2 l/min. There was no cautionary or safety signage posted at the entrance to Resident #90's room to indicate oxygen was in use. c. Resident #45 was admitted to the facility on 10/21/24. A review of Resident #45's physician orders revealed an order dated 10/22/24 for oxygen to be administered via nasal cannula at 2 l/min as needed. A review of the admission MDS dated 6/8/25 indicated Resident #45 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:21 PM revealed Resident #45 was lying in bed wearing a nasal cannula with oxygen being administered at 2 l/min. There was no cautionary or safety signage posted at the entrance to Resident #8's room to indicate oxygen was in use. An observation conducted on 6/19/25 at 9:30 AM revealed Resident #45 was lying in bed wearing a nasal cannula with oxygen being administered at 2 l/min. There was no safety signage posted at the entrance to Resident #45's room to indicate oxygen was in use. d. Resident #32 was admitted to the facility 8/9/18. A review of Resident #32's physician orders indicated an order dated 7/16/24 for oxygen to be administered	F0695		

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F0695 SS = E	Continued from page 50 via nasal cannula at 2 l/min continuously. A review of the quarterly MDS dated 5/22/25 revealed Resident #32 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:25 PM revealed Resident #32 was lying in bed wearing a nasal cannula with oxygen being delivered at 2 l/min. There was no cautionary or safety signage posted at the entrance to Resident #42's room to indicate oxygen was in use. An observation of Resident #32 was conducted on 6/19/25 at 11:30 AM. Resident #32 was lying in bed wearing a nasal cannula with oxygen being delivered at 2 l/min. There was no safety signage posted at the entrance to Resident #32's room to indicate oxygen was in use. e. Resident #4 was admitted to the facility on 1/26/24. A review of Resident #4's physician orders indicated an order dated 5/16/24 for oxygen to be administered via nasal cannula at 2l/min as needed for shortness of breath. A review of the quarterly MDS dated 6/5/25 revealed Resident #4 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:28 PM revealed Resident #4 sitting in her room without her oxygen on, concentrator was in room but not running. There was no cautionary or safety signage posted at the entrance to Resident #4's room to indicate oxygen was in use. An observation on 6/19/25 at 11:10 AM revealed Resident #4 sitting in her without her oxygen on, concentrator was in room but not running. There was no cautionary or safety signage posted at the entrance to Resident #4's room to indicate oxygen was in use. f. Resident #10 was admitted to the facility 1/25/17. A review of Resident #10's physician orders indicated	F0695		

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F0695 SS = E	Continued from page 51 an order dated 5/8/24 for oxygen to be administered via nasal cannula at 2L/min at night. A review of the quarterly MDS dated 5/14/25 revealed Resident #10 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:30 PM revealed Resident #10 in his room not wearing oxygen, concentrator was in the room but not running, oxygen tubing was draped across the bed. There was no cautionary or safety signage posted at the entrance to Resident #10's room to indicate oxygen was in use. An observation conducted on 6/19/25 at 8:30 AM revealed Resident #10 in his room not wearing oxygen, concentrator was in room but not running, oxygen tubing was draped across the bed. There was no cautionary or safety signage posted at the entrance to Resident #10's room to indicate oxygen was in use. g. Resident #27 was admitted to the facility on 3/3/23. A review of Resident #27's physician orders indicated an order dated 4/17/25 for oxygen to be administered continuously via nasal cannula 2l/min. A review of the quarterly MDS dated 4/17/25 revealed Resident #27 was coded for receiving oxygen therapy during the assessment period. An observation of Resident #27 conducted on 6/18/25 at 2:33 PM revealed Resident #27 in his room wearing a nasal cannula with oxygen being delivered at 2L/min There was no cautionary or safety signage posted at the entrance to Resident #27's room to indicate oxygen was in use. An observation of Resident #27 conducted on 6/19/25 at 10:20 AM revealed Resident #27 in his room wearing a nasal cannula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident #27's room to indicate oxygen was in use.	F0695		

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F0695 SS = E	Continued from page 52 h. Resident #61 was admitted to the facility on 5/19/23. A review of Resident #61's physician orders indicated an order dated 4/13/24 for oxygen to be administered continuously via nasal canula at 2L/min. A review of quarterly MDS dated 4/16/25 revealed Resident #61 was coded for receiving oxygen therapy during the assessment period. An observation of Resident #61 conducted on 6/18/25 at 2:38 PM revealed Resident #61 in his room wearing a nasal canula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident #61's room to indicate oxygen was in use. An observation of Resident #61 conducted on 6/19/25 at 11:05 AM revealed Resident #61 in his room wearing a nasal canula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident #61's room to indicate oxygen was in use. I. Resident #31 was admitted to the facility on 11/10/20. A review of Resident #31's physician orders indicated an order dated 1/16/24 for oxygen to be administered continuously via nasal canula at 2L/min. A review of quarterly MDS dated 6/1/25 revealed Resident #31 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:40 PM revealed Resident #31 in his room wearing a nasal canula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident #31's room to indicate oxygen was in use. An observation conducted on 6/19/25 at 12:30 PM revealed Resident #31 in his room wearing a nasal canula with oxygen being delivered at 2L/min. There was	F0695		

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F0695 SS = E	Continued from page 53 no cautionary or safety signage posted at the entrance to Resident #31's room to indicate oxygen was in use. i. Resident #36 was admitted to the facility on 6/18/24. A review of Resident #36's physician orders indicated an order dated 3/12/25 for oxygen to be administered continuously via nasal canula at 2L/min. A review of the quarterly MDS dated 6/16/25 indicated Resident #36 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:44 PM revealed Resident #36 in his room wearing a nasal canula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident ##36's room to indicate oxygen was in use. An observation conducted on 6/19/25 at 12:35 PM revealed Resident #31 in his room wearing a nasal canula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident #36's room to indicate oxygen was in use. j. Resident #26 was admitted to the facility on 10/23/24. A review of Resident #26's physician orders indicated an order dated 11/26/24 for oxygen to be administered continuously via nasal canula at 2L/min. A review of quarterly MDS dated 4/25/25 indicated Resident #26 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:48 PM revealed Resident #26 in her room wearing a nasal canula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident #26's room to indicate oxygen was in use. An observation conducted on 6/19/25 at 12:40 PM	F0695		

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F0695 SS = E	Continued from page 54 revealed Resident #31 in her room wearing a nasal canula with oxygen being delivered at 2L/min. There was no cautionary or safety signage posted at the entrance to Resident #26's room to indicate oxygen was in use. k. Resident #57 was admitted to the facility on 5/7/25. A review of Resident #57's physician orders indicated an order dated 5/7/25 for oxygen to be administered continuously via nasal canula at 2L/min as needed for shortness of breath. A review of the quarterly MDS dated 5/13/25 indicated Resident #57 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:50 PM revealed Resident #57 in his room not wearing a nasal canula, the concentrator was in the room but not in use at the time of observation. There was no cautionary or safety signage posted at the entrance to Resident #57's room to indicate oxygen was in use. An observation conducted on 6/19/25 at 12:20 PM revealed Resident #57 in his room not wearing a nasal canula, the concentrator was in the room but not in use at the time of observation. There was no cautionary or safety signage posted at the entrance to Resident #57's room to indicate oxygen was in use. l. Resident #67 was admitted to the facility on 5/7/25. A review of Resident #67's physician orders indicated an order dated 5/22/25 for oxygen to be administered continuously via nasal canula at 3L/min. A review of the quarterly MDS dated 5/22/25 indicated Resident #67 was coded for receiving oxygen therapy during the assessment period. An observation conducted on 6/18/25 at 2:55 PM revealed Resident #67 in her room wearing a nasal canula with oxygen being delivered at 3L/min. There was no cautionary or safety signage posted at the entrance to Resident #67's room to indicate oxygen was in use.	F0695		

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F0695 SS = E	Continued from page 55 An observation conducted on 6/19/25 at 10:43 AM revealed Resident #67 in her room wearing a nasal canula with oxygen being delivered at 3L/min. There was no cautionary or safety signage posted at the entrance to Resident #67's room to indicate oxygen was in use.	F0695		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff, Physician Assistant (PA), and Dialysis Nurse interviews, the facility failed to follow the physician's orders to remove a dressing to an arterial venous fistula (a surgically created connection between artery and vein in the arm used for dialysis treatments) at 9:00 PM after dialysis treatment to monitor for bleeding at the access site and to prevent potential damage to the access site and provide a bagged meal or snack for 1 of 2 residents reviewed for dialysis (Resident #101). Findings included: a. Resident #101 was initially admitted to the facility on 02/20/24. Resident #101's diagnoses include end-stage kidney disease, cerebral infarction (stroke), muscle weakness, and limited mobility. The care plan originally initiated 02/20/24 for Resident #101 revealed Resident #101 required hemodialysis. The stated goal was Resident would have decreased complications from dialysis. Interventions included no blood pressures or blood draws from left arm, monitor labs as ordered, monitor fistula site for bleeding or signs of infection, monitor for signs of decreased renal function, and monitor for edema.	F0698	F698 Dialysis Problem Statement: The facility failed to remove resident #101 dialysis dressing on 11/20/2024 causing resident #101 to have her scheduled dialysis treatment, and that a bagged lunch was not sent with resident #101 on dialysis days. All residents who receive dialysis treatment have the potential to be affected by this deficient practice. A 100% audit of all residents with dialysis services for appropriate physicians' orders including the frequency and monitoring for the access, and bagged lunch is provided to residents. Education took place from July 17, 2025, to July 22, 2025, for all registered and licensed nurses, including contract staff, conducted by the Staff Development Coordinator. The training focused on the necessity of obtaining a physician's order for residents receiving dialysis, as well as the importance of frequent monitoring of the access site and providing a packed lunch. The Dietary Manager was educated by the Facility Administrator on 7/18/2025 that the dietary department was responsible for preparing a bagged lunch for all dialysis residents on dialysis days. The Dietary Manager educated the dietary staff on preparing a bagged lunch for dialysis residents on dialysis days beginning on 7/18/2025 through 7/22/2025. Any staff members who have not worked or are newly hired, including contract staff, will receive training from the Staff Development Coordinator before their first shift after July 22, 2025. The Director of Nursing or Assistant Director of Nursing will complete an audit of residents receiving dialysis, physician orders for frequent and monitoring of the site access and receiving a bagged lunch, 3 times per week for 4 weeks, then weekly times 4 weeks, then monthly times 3 months. If an issue is found, an order will be obtained, and the nursing staff will be retrained by the staff development coordinator. The audit tool will be brought to the Quality Assurance	07/22/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD , NEBO, North Carolina, 28761

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F0698 SS = D	Continued from page 56 A review of dialysis communication sheet dated 10/16/24 written by the Dialysis Nurse revealed a note indicating "please ensure dressing removed from access arm each evening after treatment to prevent clotting of access. It does not work well when pressure dressing left on too long." A review of dialysis communication sheet dated 10/20/24 written by the Dialysis Nurse revealed under other concerns a note "please remove gauze dressing from dialysis site the night of dialysis. Leaving it on can damage access." A physician's order written on 11/01/24 to remove dressing to left arm dialysis access site at 9:00 PM after return from dialysis each evening on Monday, Wednesday, and Friday. A review of Resident #101's progress notes revealed a note dated 11/08/24 that dialysis clinic notified facility that Resident #101's dialysis dressing should be removed at 9:00 PM on Monday, Wednesday, and Friday after dialysis appointments. A review of dialysis communication sheet dated 11/13/24 revealed directions from the dialysis center "per physician order, remove pressure dressing by 9:00 PM on Monday, Wednesday, and Thursday." A phone interview was conducted with the Dialysis Nurse on 06/18/25 at 10:07 AM. The Dialysis Nurse stated that on 11/20/24 Resident #101 was unable to have her scheduled dialysis performed due to pressure dressing from 11/18/24 dialysis appointment still present over dialysis port. The Dialysis Nurse stated because the facility did not remove the dressing for an extended period of time, pressure resulted in swelling to the arterial venous fistula. The Dialysis facility was unable to access the fistula to perform dialysis due to excessive swelling around port on 11/20/24. Dialysis Nurse reported that the facility was notified by telephone that Resident 101's dialysis treatment could not be completed due to pressure dressing left in place. Resident #101's responsible party was also notified on 11/20/24 by Dialysis Nurse. The Dialysis Nurse indicated that instructions to remove Resident #101's pressure dressing at 9:00 PM after dialysis treatments on Monday, Wednesday, and Friday had been repeatedly communicated to facility via dialysis	F0698	Continued from page 56 Committee monthly for 3 months by the Director of Nursing to ensure compliance. The facility licensed nursing home administrator is responsible for implementing this plan of correction. Date of compliance : 7/22/2025	

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F0698 SS = D	Continued from page 57 communication form. The Dialysis Nurse stated the risks of missed dialysis would be fluid build-up, electrolyte imbalances, and congestive heart failure due to fluid overload. The Dialysis Nurse reported that Resident 101's dialysis was rescheduled for 11/21/24. Resident #101 was able to have dialysis completed on 11/21/24 because swelling of the dialysis port had decreased. The nurse assigned to Resident #101 on 11/18/24 was not available for interview. A review of Resident 101's November 2024 medication administration record (MAR) revealed an order dated 11/20/24 to remove the dressing to left arm dialysis access site at 9:00 PM on Monday, Wednesday, and Friday. No previous order was noted on the MAR for dialysis port dressing removal. A review of the annual Minimum Data Set (MDS) dated 01/21/25 revealed Resident #101 was severely cognitively impaired and received dialysis. An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM revealed she does not recall the dialysis center report that the pressure dressing had not been removed on 11/18/24 and stated the dialysis center may have spoken to the Administrator. The DON stated that Resident 101's dialysis site would bleed so it was possible the dressing was left on due to bleeding. The DON indicated that if Resident #101 had bleeding to dialysis port, the nurse assigned would notify the provider, contact the dialysis center, and document. The DON reviewed the MAR which had order dated 11/20/24 to remove pressure dressing at 9:00 PM. She stated that she does not think there was an order prior to that date. An interview with the PA on 06/20/25 at 10:26 AM revealed that he was not aware that Resident #101 could not receive her dialysis on 11/20/24 due to Resident 101's dressing not removed after dialysis on 11/18/24 caused swelling to port. He indicated that if the pressure dressing was not removed, it could cause swelling which would prevent access. The PA indicated complications from missed dialysis would include swelling, fluid overload, and heart failure. He reported he was not aware of any complications related to Resident #101's missed dialysis and stated that Resident #101 was stable.	F0698		

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F0698 SS = D	Continued from page 58 An interview with the Administrator on 06/20/25 at 11:59 AM revealed that the dialysis center had notified her via phone on 11/20/24 that Resident #101 could not receive her dialysis due to dressing not removed after 11/18/24 dialysis treatment. The Administrator reported that Resident #101's dialysis port sometimes came back still bleeding and believed that is why the dressing was not removed as ordered. The Administrator stated that the Nurse should have notified the provider if there was complication that prevented dressing from being removed. b. A physician's order written on 12/11/24 revealed Resident to receive dialysis on Monday, Wednesday, and Friday at 11:30 AM at the dialysis center. A phone interview conducted with the Dialysis Nurse on 06/18/25 at 10:07 AM. The Dialysis Nurse stated that Resident #101 had scheduled dialysis on Monday, Wednesday, and Friday at 11:30 AM. The Dialysis Nurse indicated that Resident #101 had not received a bagged lunch or snack from facility during dialysis treatments to her knowledge. The Dialysis Nurse reported that residents undergoing dialysis were able to eat small meal or snack at the dialysis center. The Dialysis Nurse further indicated that some residents get nauseous through treatment but Resident #101 had not reported any nausea or had any vomiting noted. An interview with Nurse #16 on 06/19/25 at 10:13 AM who stated that prior to dialysis the nurse would check Resident #101's vital signs, assess for bruit and thrill at dialysis port, give medications, and Resident #101 would eat breakfast. Nurse #16 reported that she does not know if they send any snacks or a bagged lunch. She stated that the staff that transport Resident #101 would be responsible for that. An interview with Driver #2 on 06/19/25 at 10:50 AM indicated that she does not take a bagged lunch or snack with Resident #101 to dialysis treatment. An interview with the Dietary Manager on 06/18/2025 at 2:50PM indicated bagged lunches were not prepared for residents that went to dialysis. The Dietary Manager revealed she was unaware a bagged lunch needed to be sent with residents who received dialysis.	F0698		

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F0698 SS = D	Continued from page 59 An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM revealed she was not aware that a bagged lunch or snack should be sent with Resident #101 to dialysis appointment. The DON stated that Resident #101 would eat breakfast before she went to dialysis. An interview on 06/20/25 at 11:59 AM with the Administrator revealed that Resident #101 usually ate breakfast and got back around dinner time and that they were not allowed to eat at dialysis so no bagged lunch or snacks were sent with Resident #101.	F0698		
F0757 SS = E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, and Consulting Pharmacist, Psychiatric Nurse Practitioner, and Physician interviews, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale)	F0757	F757 Unnecessary Drug F757 the facility failed to complete AIMS test for resident #15 every 6 months per pharmacy recommendations. Corrective action for resident(s) affected by the alleged deficient practice: For resident #15, on 6/17/2025 the facility completed the AIMS test by the Director of Nursing. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring medications requiring AIMS testing have the potential to be affected by this alleged deficient practice. On 7/15/2025 the Staff Development Coordinator and Unit Managers began auditing all medications requiring AIMS testing to ensure timely completion was up to date. This was completed on 7/18/2025. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/17/2025 the Staff Development Coordinator began education of all Full Time, Part Time, as needed nurses, to include agency on Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate drug therapy); or for excessive duration; or Without adequate monitoring; or Without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. Including the process for completing AIMS testing. This information has been integrated into the standard orientation training for all licensed nursing staff identified above and will be reviewed by the	07/22/2025

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F0757 SS = E	Continued from page 60 assessment for 1 of 5 residents reviewed for unnecessary medications (Resident #15). The findings included: Resident #15 was admitted to the facility on 11/27/2019 with diagnosis that included late onset Alzheimer's disease with behavior disturbance, dementia with mood disturbances, recurrent major depressive disorder, major neurocognitive disorder due to dementia, generalized anxiety disorder, primary insomnia. A review of Resident #15's Physician's orders revealed an order dated 2/6/2024 for Zyprexa (an atypical antipsychotic) 2.5 milligrams (mg) give one tablet by mouth two times a day for mood disorders. A quarterly Minimum Data Set (MDS) assessment dated 4/19/2025 revealed Resident #15 was severely cognitively impaired and indicated Resident #15 received an antipsychotic on a routine basis during the 7-day look back period and that a Gradual Dose Reduction (GDR) clinically contraindicated on 4/2/2025. The MDS also indicated Resident #15 exhibited verbal behaviors symptoms directed toward others. A review of Resident #15's electronic medical record revealed an AIMS test was completed on 5/31/2024. Review of the Consulting Pharmacist recommendations dated 4/18/2025 revealed a recommendation for nursing that read: "This resident is taking medications that can cause extrapyramidal side effects. An AIMS test should be done at baseline and every 6 months thereafter." The recommendation indicated the date of Resident #15's last AIMS test was 5/31/2024. Review of the progress notes revealed a note dated 5/15/2025 at 11:24 PM written by the Consulting Pharmacist that read: Medication Regimen Review completed. No Recommendation. A telephone interview was conducted with the Consultant Pharmacist on 6/19/2025 at 1:48 PM. The Consulting Pharmacist stated that it was recommended that residents taking Zyprexa have an AIMS test completed	F0757	Continued from page 60 Quality Assurance process to verify that the change has been sustained. Any of the above nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 7/22/2025. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nurses or designee will audit for compliance with AIMS testing for 5 residents weekly x 3 weeks then monthly x 2 months or until resolved. Reports will be presented to the monthly QAPI committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Date of compliance: 7/22/2025	

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F0757 SS = E	Continued from page 61 every 6 months. The Consulting Pharmacist verified during the Monthly Regimen Review (MRR) dated 4/18/2025 he recommended that Resident #15 needed an AIMS baseline then every six months, and that the last AIMs documented for resident #15 was 5/31/2024. The Consulting Pharmacist stated an AIMS assessment every 6 months was the recommended best care practice, and he could have recommended the assessment be completed before April of 2025, but the facility had completed one on 5/31/2024. The Consulting Pharmacist stated if they had not completed any monitoring he may have made the recommendation sooner. The Consulting Pharmacist stated when his recommendations were submitted the facility had 30 days to complete the recommendations. During a telephone interview on 6/25/2025 at 10:03 AM the Psychiatric Nurse Practitioner (Psych NP) stated AIMS tests were recommended every 6 months when taking Zyprexa, but Resident #15 was taking a very low dose of Zyprexa. During an interview on 6/18/2025 at 10:27 AM the Weekend Supervisor stated if an assessment was due for a resident, the electronic medical record (EMR) would show an alert or flag in the residents EMR that an assessment was due under a section labeled "UDA" (Un-done Assessments). The Weekend Supervisor stated nurses were responsible for checking the EMR for assessments that are due, and unit managers also monitored residents electronic medical record to make sure assessments were completed. The Weekend Supervisor stated she helped monitor assessments and would assist the nurses to make sure they were completed when needed, but did not know who entered them into the EMR. During a telephone interview on 6/26/2025 at 11:23 AM the Physician stated residents who received Zyprexa should have an AIMS assessment completed every 6 months per recommendations. During an interview with the Director of Nursing (DON) on 6/19/2025 at 5:20 PM the DON stated the Consulting Pharmacist emailed recommendations to the provider and DON. The DON stated she was responsible for completing nursing recommendations received from the Consulting Pharmacist. The DON stated she had received the April 2025 recommendation which indicated Resident #15 needed an AIMS assessment completed. The DON stated the AIMs assessment should have been completed when the recommendation was received, since the Consulting	F0757		

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F0757 SS = E	Continued from page 62 pharmacist had recommended it be completed every six months. The DON stated the AIMs assessment would be completed in the electronic record under assessments, and she was responsible for completing the recommended assessment. The DON was unsure if the AIMs assessment had been entered into Resident #15 ' s EMR to be completed every 6 months. The DON stated she normally completed the recommendations from the Consulting Pharmacist but did delegate to others at times. The DON stated when the pharmacy recommendation was requested by the surveyor, the DON realized the recommended AIMS assessment for Resident #15 had not been completed. The DON stated she would normally go out and complete the assessment as soon as a recommendation was received, but she must have forgotten to complete the one for Resident #15. During an interview with the Administrator on 6/20/2025 at 7:50 AM the Administrator stated she expected AIMS to be completed per pharmacy recommendations. The Administrator stated it was possible the assessment was completed on paper and had not been uploaded into the electronic chart. No further AIMS assessments for Resident #15 were provided by the Administrator.	F0757		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on record review, medication administration observations, and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by the omission of two medications due to being unavailable (2 medication errors out of 30 opportunities), resulting in a facility medication error rate of 6.67% for 1 of 13 residents (Resident #106) observed during medication pass. The findings included: Resident #106 was admitted to the facility on 04/02/24	F0759	F759 medication error rate 5% or more Resident # 106 had medication error form completed with physician notification. Nurse #12 omitted the dose of 2 medications on 6/18/2025. All residents have the potential to be affected by this deficient practice. All Certified Medication Aides and Licensed Nurses will have a medication pass audit completed by nurse managers/ designee to ensure there are no issues by 7/22/2025. All licensed nurses and Certified Medication Aides will attend an in-service training regarding the administration of medications as ordered by physicians. This training will be conducted by the Staff Development Coordinator or their designee, and will take place from July 17, 2025, to July 22, 2025. Any newly hired licensed nurse or Certified Medication Aide will receive this in-service training during their orientation, facilitated by the Staff Development Coordinator or their designee. Additionally, any new agency staff will receive this education before their first shift, conducted by the Staff Development Coordinator or their designee. A medication administration audit will be completed on	07/22/2025

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F0759 SS = D	Continued from page 63 with diagnoses that included chronic respiratory failure, iron-deficiency anemia, and stage 4 pressure ulcer. A physician order for Resident #106 dated 10/09/24 read: guaifenesin (medication to clear mucus) 20 milliliters (mL) per g-tube (tube in stomach) 4 times per day for chest congestion. A physician order for Resident #106 dated 01/25/25 read: multivitamin liquid 30 milliliters (mL) per g-tube daily. On 06/18/25 at 8:13 AM, Nurse #12 was observed as she prepared Resident #106's medications. Nurse #12 noted there was no multivitamin liquid or guaifenesin liquid on the medication cart for Resident #106. Nurse #12 reported that she had checked the medication room, and neither were available in back-up supply. Nurse #12 then prepared Resident #106's other medications and administered them. Nurse #12 omitted the dose for the multivitamin and guaifenesin for Resident #106 but did not notify the provider that medications were not available. A review of Resident 106's June 2025 medication administration record (MAR) revealed that Nurse #12 documented "9" which meant "other-see progress notes" under the 8:00 AM multivitamin and guaifenesin administration on 06/18/25. A review of Resident #106's progress notes revealed no progress notes dated 06/18/25 related to medication administration. An interview with Nurse #12 on 06/18/25 at 8:41 AM revealed she was aware that Resident #106's medications were not available. Nurse #12 stated that normally, she would notify the provider to either omit the dose or order an alternative medication. Nurse #12 stated that they do run out of stock medications at times. Nurse #12 indicated she was nervous during the observation and did not call the provider and just omitted the dose of multivitamin and guaifenesin without an order. An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM revealed the DON would investigate	F0759	Continued from page 63 1 nurse or CMA 3 times a week times twelve weeks by the Director of Nursing/ designee to ensure medications are not omitted. The results of these audits will be forwarded by the Director of Nursing/ designee to the Quality Assurance and Performance Improvement Committee times 3 months. Date of Compliance: 7/22/2025	

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F0759 SS = D	Continued from page 64 what caused Nurse #12 to omit the dosages of guaifenesin and multivitamin without provider notification, but it was probably because she didn't have the medication available. The DON stated that Nurse #12 should have notified the provider that medications were not available. The DON stated that the nurses were supposed to follow the five rights of medication administration. The DON stated that if a medication was not available, then medication would need to be reordered by the Unit Manager #3.	F0759		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and resident, staff, Physician Assistant, and Physician interviews, the facility failed to prevent a significant medication error when nursing staff failed to administer a scheduled pain medication as ordered by the physician. Resident #117 was ordered to receive a scheduled pain medication twice a day and failed to receive a morning dose of scheduled pain medication due to the medication not being available at the facility. This deficient practice occurred for 1 of 2 residents reviewed for significant medication errors (Resident #117). The findings included: Resident #117 was admitted to the facility on 11/13/2024 with diagnoses of left clavicle fracture, multiple fractures of the pelvis, left hip fracture, left leg fracture, and chronic pain. Review of the Physician order dated 11/24/2024 stated to administer Methadone 35 milligrams (mg) by mouth twice a day for pain (methadone is a key medication for treating opioid use disorder and can also be used for pain management). A review of Resident #117's quarterly Minimum Data Set (MDS) assessment dated 02/26/2025 revealed Resident #117 had moderately impaired cognition. The MDS also	F0760	F760 Free from Significant Medication Error 1. Facility failed to prevent significant medication error when staff failed to administer a scheduled pain medication as ordered by the physician for resident #117. Nurse #2 failed to call the physician when scheduled pain medication was not available and failed to notify the physician for alternative interventions. 2. The Director of Nursing and or designee(s) interviewed cognitively intact residents to ensure on 4/17/2025 and 4/18/2025 there were no reported issues involving receiving scheduled medication. No issues were identified. 3. The Director of Nursing and or designee(s)educated Nurses and medication of the "Five Rights" of medication administration on 7/17/2025 thru 7/22/2025. The process of reporting unavailable medication to the provider for alternative interventions. 4. The Director of Nursing and or designee(s)will interview 3 cognitively intact residents weekly for 4 weeks, then biweekly for 4 weeks, then monthly for 3 months to ensure compliance. The audit tool will be brought to the Quality Assurance Committee monthly for 3 months by the Director of Nursing to ensure compliance. 5. Date of compliance: 7/22/2025	07/22/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD , NEBO, North Carolina, 28761

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F0760 SS = D	Continued from page 65 revealed Resident #117 received scheduled pain medications. Review of Resident #117's revised comprehensive care plan dated 03/01/2025 revealed no care plan was developed related to pain management or the use opioid medications. Review of the Medication Administration Record (MAR) for April 2025 revealed Methadone 35 mg twice a day was coded as not available to be administered to Resident #117 as scheduled on 04/16/2025 at 9:00 AM. Review of the Pharmacy Consolidated Delivery Sheet dated 04/16/2025 revealed 210 tablets of Methadone 10 mg was delivered to the facility for Resident #117 at 4:00 PM on 04/16/2025. An observation and interview was conducted with Resident #117 on 06/17/2025 at 2:13 PM. Resident #117 was sitting up in his wheelchair watching television. Resident #117 appeared comfortable and did not verbalize any complaints of pain or discomfort. Resident #117 stated he has had issues with pain for a very long time because he was in an automobile accident in 2023 and suffered severe injuries including multiple broken bones and abdominal trauma. Resident #117 further stated that he had chronic pain as a result of his automobile accident and had received oxycodone for a very long time for pain control, but he was now taking Methadone twice a day. He also stated that the Methadone controlled his pain. Resident #117 stated that he remembered the day when he did not get his morning dose of Methadone. Resident #117 stated that he did not feel well the entire day, and he didn't have any energy, but he did not know if it was because he didn't get his pain medication or not. He also revealed he did not understand why the facility did not keep his scheduled pain medication in stock especially since he had been taking the medication for so long. An interview was conducted with Nurse #2 on 06/18/2025 at 1:15 PM and revealed she recalled Resident #117's scheduled pain medication being unavailable to administer during her morning medication pass on 04/16/2025. She stated she did not contact the physician, but she contacted the pharmacy to request Resident #117's scheduled pain medication and reported it to the on-coming nurse.	F0760		

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F0760 SS = D	Continued from page 66 An additional interview was conducted with Resident #117 on 06/19/2025 at 10:13 AM. Resident #117 revealed he missed his morning dose of his scheduled pain medication on Wednesday 04/16/2025 due to the facility running out of it but the pharmacy was able to send more, and he received his next scheduled dose at 9:00 PM that night. He stated he still did not understand why the facility was not able to keep his scheduled pain medication in stock or why the staff did not send in an order to pharmacy when they would see that his medication was running low. An interview with the physician on 06/19/2025 at 1:19 PM revealed she was not aware of Resident #117 missing a dose of his scheduled pain medication. The physician also stated she would consider Resident #117 missing his scheduled dose of Methadone as a significant medication error. The physician explained that possible negative effects of missing a scheduled dose of Methadone could include sweating, severe nausea and vomiting, abdominal cramping, pain, and diarrhea. An interview with the Physician Assistant (PA) on 06/19/2025 at 2:15 PM revealed he was familiar with Resident #117 who suffered from chronic pain due to an automobile accident which resulted in multiple fractures and a prolonged hospital stay. The PA stated that Resident #117 had received oxycodone (a pain mediation used to treat severe pain) initially when he was admitted to the facility but Resident #117 had transitioned to Methadone for his chronic pain management. The PA explained that he was aware of Resident #117's missed dose of Methadone. He further explained that the facility should always have resident medications available and should not wait until the last dosage of a medication to re-order especially since they account for resident medications on every shift. An interview was conducted with the Director of Nursing (DON) on 06/19/2025 at 3:05 PM. She stated she aware of Resident #117's missing his morning scheduled pain medication on 04/16/2025. She revealed residents should have their medication available to be administered as ordered. The DON stated nursing staff should be re-ordering resident medications prior to the resident's last dose to keep from running out, and if nursing staff is not aware of how to re-order they should notify their unit manager so the medication	F0760		

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F0760 SS = D	Continued from page 67 could be ordered in a timely manner. An interview with the Administrator was conducted on 06/19/2025 at 4:00 PM. She stated she was aware of Resident #117 missing his scheduled pain medication due to the medication not being available. She revealed the facility should have all resident medications available to be administered as ordered, and nursing staff should be re-ordering resident medication prior to them running out.	F0760		
F0761 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 observations, record reviews, and staff interviews, the facility failed to secure 2 medication cards during medication administration for 2 of 13 residents reviewed for medications (Resident #109 and Resident #104). In addition, the facility failed to date an multi-dose medication vial when opened and store a medication vial in the refrigerator per the manufacturer's instructions in 2 of 2 medication	F0761	F761 Label/Store Drugs and Biologicals Address how corrective action will be accomplished for those residents found to have been affected by alleged deficient practice: Nurse #13 was verbally educated on 6/17/2025 for leaving medications for resident #109 unattended on the top of the medication cart. Facility failed to place opened date of multi- use vial of Tuberculin Purified Protein Derivative and Acetylcysteine in the north medication room on 6/17/2025. Medications immediately disposed of by the Director of Nursing. Unit Managers inspected all medication carts and medication rooms to ensure that none were expired and dated appropriately with opened and expiration date on 7/17/2025. Address how the facility will identify other residents having the potential to be affected by the same practice alleged deficient practice: All residents with medications were identified as having the potential to be affected. Staff Development Coordinator/Designee performed Audit of all Medication carts and medication rooms on 7/17/2025. Staff Development Coordinator educated all current Nurses and Medication Aides for proper medication storage and labeling on 7/17/2025 thru 7/22/2025. Address what systemic changes made to ensure that the alleged deficient practice will not recur: Medication carts and medication rooms will be inspected weekly by the unit managers/designee to ensure there are no medications left unattended on the medication cart and medications are dated appropriately with open and expired dates. Education for Label/Store Drugs and Biologicals was completed on 7/22/2025 by the SDC for current licensed	07/22/2025

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F0761 SS = D	Continued from page 68 storage rooms (North and South hall medication storage rooms). The findings included: During continuous observation of medication administration with Nurse #13, conducted on 06/17/25 at 2:04 PM one medication card of Resident #109's midodrine tablets with 10 doses was left unattended on top of the medication cart. Nurse #13 walked away from the medication cart, into Resident #109's room and behind the privacy curtain out of eyesight of the medication cart. At 2:14 PM, one medication card of Resident #104's gabapentin 300 mg capsules with 24 doses were left unattended on top of the medication cart when Nurse #13 walked away from medication cart, into Resident #109's room and behind the privacy curtain out of eyesight of the medication cart. During an interview with Nurse #13 on 06/17/25 at 2:16 PM Nurse #13 reported that she felt nervous while medication administration was observed and left Resident #109 and Resident #104's medications unsecured on top of the medication cart. She stated she did not realize that medications were left out until she returned to the medication cart. During an interview conducted with the Director of Nursing (DON) on 06/19/25 at 1:11 PM, she stated all nursing staff should be attentive during medication administration to ensure no medications were left unattended in the facility. An interview conducted with the Administrator on 06/19/25 at 4:15 PM indicated all nursing staff should ensure no medications were left unattended on top of the medication cart during medication administration. The facility should remain free of unsecured medications. 2. Review of the manufacturer's recommendations revealed the Acetylcysteine medication vial was good for 96 hours after opening if refrigerated. An observation of the North Hall medication storage room was conducted on 06/17/2025 at 12:07 PM with the Director of Nursing (DON). An opened multi-use vial of	F0761	Continued from page 68 nursing staff. Licensed Nursing staff who are not available for education on 7/22/2025 will not be allowed to work until education is completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON/Designee will conduct audits on all Medication carts for expired medications 5 days per week x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. Quality Reviews will be forwarded to QAPI monthly until QAPI until IDT concludes the goal has been achieved. Date of corrective action: 7/22/2025	

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F0761 SS = D	Continued from page 69 Tuberculin Purified Protein Derivative with a manufacturer's expiration date of 01/2028 was found in the North Hall medication room in the refrigerator. The tuberculin vial was not labeled with an open date. An observation of the South Hall medication storage room was conducted with the Director of Nursing (DON) on 06/17/2025 at 12:37 PM. An opened multi-use vial of Acetylcysteine Solution (inhalation medication used to relieve chest congestion due to thick mucus secretions) with a manufacturer's expiration date of 02/2026 was found in the top right drawer of the medication room. The Acetylcysteine vial was not labeled with an open date, and the pharmacy label was illegible. An interview was conducted with the DON on 06/17/2025 at 1:00 PM. The DON stated the tuberculin medication vial should have been labeled with an open date. The DON further explained the tuberculin vial should be labeled with an open date because the Tuberculin medication vials were only good for 30 days after opening. The DON also stated that she did not know the open vial of Acetylcysteine should have been stored in the refrigerator and she did not know how long the medication was good for after being opened. An interview was conducted with the Administrator on 06/17/2025 at 1:44 PM. The Administrator stated that she expected all multi-dose vials to have an open date. The Administrator also stated that she expected all medications be stored and discarded as recommended by the manufacturer.	F0761		
F0777 SS = G	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.	F0777	F777 The statements included are not admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance with state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be completed by the date indicated. Corrective action will be accomplished for those residents found to have been affected by the deficient	07/22/2025

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F0777 SS = G	Continued from page 70 This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, mobile x-ray company representative, and Physician Assistant and Physician interviews, the facility failed to notify the provider of x-ray results when they were reported to the facility on 12/29/24, which resulted in Resident #15's right hip fracture not being reported to a provider until 12/30/24 which delayed Resident #15's transfer to the hospital until 12/30/24 for an evaluation and treatment for a right hip fracture that required surgical intervention for 1 of 4 residents reviewed for falls (Resident #15). The findings included: Review of the progress note dated 12/28/2024 written by the Director of Nursing (DON) revealed the DON heard Resident #15 yelling and as the DON arrived at Resident #15's doorway the DON observed Resident #15 as she attempted to get out of bed. The DON was unable to reach Resident #15 before she fell onto her right side onto the floor mat. Resident #15 did not strike her head but yelled out "my hip is broken". The DON assessed Resident #15, leg heights could not be assessed due to mild contraction. Resident #15 expressed pain when area was touched. Facility Physician Assistant (PA) was notified and orders were received to obtain right hip x-ray and to give one time dose of oxycodone 2.5 milligrams (mg) related to acute right hip pain. The progress note indicated Resident #15 was assisted back to bed by staff x 3 and x-ray was pending. Review of Resident #15's orders revealed on 12/28/2024 the PA ordered an x-ray of Resident #15's right hip. An interview with the DON on 6/20/2025 at 11:04 AM revealed she cared for Resident #15 on 12/28/2024 3:00 PM to 11:00 PM. The DON stated on 12/28/2024 she heard Resident #15 yelling for help and when she came to the door Resident #15 was attempting to get out of bed and the DON was unable to reach Resident #15 in time, Resident #15 fell out of her bed, onto her right side. The DON stated Resident #15's bed was in the low position and Resident #15 had fallen onto her fall mat next to the bed. The DON stated Resident #15 yelled that her hip was broken. The DON stated she immediately assessed Resident #15. The DON stated due to Resident	F0777	Continued from page 70 practice: Resident #15 resides in the facility, plan of care reviewed and updated based upon the assessed needs to ensure that adequate supervision is provided. Staff shall maintain timely communication with physicians regarding any accidents, incidents and/or changes of condition. Identification of residents having the potential to be affected by the same deficient practice: On 7/17/25, the Interim Director of Nursing and Unit Managers reviewed all active residents fall incidents from 6/24/2025 to 7/17/2025, to determine if any other outstanding radiology results had not been provided or called in to the providers. No other incidents were identified. Measures / systemic changes made to ensure that the deficient practice will not recur: On 7/17/25, the Interim Director of Nursing initiated in-service training with all licensed nurses including agency licensed nurses regarding their role in ensuring radiology results are communicated timely to the resident's ordering physician and/or provider. The in-service included the following: (1) radiology results should be communicated to the ordering physician within your shift, (2) After-hours and on weekends, call the on-call physician for notification of results within your shift, (3) Document in the resident records the communication with the ordering physician and availability of the radiology results. If orders are received, document that as well in resident records. All licensed nurses, including agency licensed nurses who have not received this education by 7/22/25 will not be allowed to work until this training has been completed. This education will be included in the new hire and agency orientation process for all licensed nurses to ensure compliance. Facility plans to monitor performance to make sure solutions are sustained:	

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F0777 SS = G	Continued from page 71 #15's legs being contracted it was difficult to assess the length of Resident #15's legs. The DON stated she called the facility PA to report the fall and received orders for a right hip x-ray and oxycodone 2.5mg for pain. The DON stated she called in the order for the right hip x-ray to the mobile x-ray service. The DON stated the x-ray was not called in stat. The DON stated when a mobile x-ray was ordered on the evening or weekend the x-ray was sometimes not completed until the next day. The DON stated she reported to 3rd shift that an x-ray was to be completed for Resident #15. The DON stated that typically the mobile x-ray reports were automatically uploaded into the resident electronic medical record. If there was positive fracture results the mobile x-ray company would call and alert the facility. Once the facility was notified, she would expect the staff to immediately notify the provider for further orders. The DON added that she believed there was a delay in the facility receiving the x-ray report which also delayed Resident #15 in being transferred to Emergency Room(ER) for evaluation. During an interview on 6/20/2025 at 8:52 AM the Physician Assistant (PA) stated he had received a call from the DON regarding Resident #15 and a fall. The PA stated he did not recall the DON reporting that Resident #15 yelled "my hip is broken", but he did recall the DON reported Resident #15 had voiced pain. The PA stated Resident #15 was not a reliable historian. The PA stated he had received report Resident #15 did not have leg shortness. The PA stated he ordered for a hip x-ray to be completed and a one time extra dose of oxycodone 2.5mg. The PA stated normally it would take the mobile x-ray about company around four hours to arrive and perform an x-ray, but on evenings and weekends it sometimes took longer. Review of Resident #15's electronic medical record (EMR) revealed no documentation regarding Resident # 15's right hip or x-ray in the progress notes that were dated 12/29/2024. During a telephone interview on 6/20/2025 at 12:12 PM Nurse #4, who was scheduled on Resident #15's hall on 12/28/2024 and 12/29/2024 from 11:00 PM until 7:00 AM, stated he did not recall Resident #15 specifically or any information related to a fall. He stated he may have been scheduled to take care of Resident #15 but did not remember back that far.	F0777	Continued from page 71 The Director of Nursing or designee will review radiology results daily (Monday –Friday) x 4 weeks then biweekly x 4 weeks, then monthly x 2 months to ensure radiology results have been reviewed and communicated to the ordering physician. The Director of Nursing will present the findings of the audits to the Quality Assurance and Performance Committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained ongoing, and determine the need for further monitoring. Date of compliance 7/22/25	

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F0777 SS = G	Continued from page 72 Review of Resident #15's electronic medical record revealed no documentation regarding Resident # 15's right hip or x-ray in the progress notes that were dated 12/29/2024. Review of the x-ray completed on 12/29/2024 with results reported to the facility on 12/29/2024 at 2:09 PM revealed Resident #15 sustained an acute right femoral intertrochanteric fracture. Multiple attempts to reach Nurse #17, who worked with Resident #15 on 12/29/2024 from 7:00 AM to 3:00 PM were unsuccessful. Multiple attempts to reach Nurse #18 who worked with Resident #15 on 12/29/2024 from 3:00 PM to 11:00 PM were unsuccessful. Review of a progress note dated 12/30/2024 written by Nurse #5 revealed x-ray results were received and reported to the facility PA and orders to send Resident #15 to the emergency room for further evaluation and treatment of right hip were received. Report was called to the hospital and Resident #15 was transferred to the hospital. During a telephone interview on 6/20/2025 at 4:35 PM Nurse #5 stated she was not at work when Resident #15 fell but worked on 12/30/24 and received the x-ray results. Nurse #5 she answered a call from the mobile x-ray company, who called to verify the facility had received the x-ray results for Resident #15. Nurse #5 stated after she received the call, she checked Resident #15's Electronic Medical Record (EMR) and was able to view the radiology results. Nurse #5 stated she saw that the report indicated a fracture, she printed the report and immediately brought it to the facility PA who reviewed the x-ray report and gave orders to send Resident #15 to the emergency room. Nurse #5 stated once she received the order from the PA she immediately called 911 for transport and started the process to send Resident #15 to the hospital. Nurse #5 stated nurses can view results or reports from x-rays in the residents EMR, and stated when you are in the residents EMR the radiology and lab section will have an alert that results are available. Review of Resident #15's electronic medical record	F0777		

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F0777 SS = G	Continued from page 73 revealed a progress note dated 12/30/2025 at 1:16 PM written by a Nurse Practitioner (NP) that indicated Resident #15 had reported pain at a 10 out of 10 when she was assessed, but in no apparent distress, and no tenderness to palpation of bilateral upper and lower extremities, unable to test range of motion in the right lower extremity due to increased pain, and nursing reports she is being sent to the hospital for right hip fracture. During a telephone interview on 6/20/2025 at 1:06 PM with the mobile x-ray company Representative , the Representative stated they were notified on 12/28/2024 at 4:32 PM that the facility needed mobile x-ray for a resident, and stated it was not ordered stat, and that stat orders were completed the same day. The Representative stated the x-ray was done on 12/29/24 at 12:52 PM and the images were released at 1:19 PM. The Representative revealed the x-ray report was faxed to the facility at 2:09 PM, which meant the x-ray results would be available in the resident's electronic medical record for the facility to view. The Representative further stated they attempted to call report to the facility five times on 12/29/2024 with no answer by the facility. The Representative reported on 12/29/24 they made the first call at 3:47 PM, and calls were made every 30 minutes four additional times with no answer at the facility. The Representative indicated on 12/30/2024 the mobile x-ray company reached someone at the facility at 8:59 AM and spoke with Nurse #5 and gave her the report findings of positive fracture. During an interview on 6/20/2025 at 2:58 PM the Unit Manager #1 stated an x-ray order called in to the mobile company in the evening could possibly be completed that night if called in as a stat order, but if not called in as a stat order on an evening or weekend it would normally not be completed until the next day. The Unit Manager #1 stated when there is a result of a positive fracture on an x-ray the mobile x-ray company would call the facility to report the results and get the name of the person that received the report. The Unit Manager #1 stated when the mobile x-ray called the facility, the call would ring at the nurses desk and the call would transfer to the other nurses station if not answered. The Unit Manager #1 stated that on the weekend during second shift the phone could have gone unanswered, but the nurses should do their best to answer the phone when it rings especially when an x-ray report was pending.	F0777		

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F0777 SS = G	Continued from page 74 During an interview on 6/20/2025 at 11:51 AM The PA stated when he arrived to the facility on 12/30/2024 he was informed of Resident #15's x-ray results and immediately gave orders for her to be sent to the hospital for an orthopedic evaluation. The PA stated they have on call providers on the weekend and ideally the x-ray results should have been reported to him or the on-call provider when received on 12/29/2024. During a telephone interview on 6/25/2025 at 11:23 AM the facility's Physician stated when x-ray results were released by the mobile x-ray company, and nurse would have access to the reports in a residents EMR. The Physician stated the mobile x-ray company also faxed a report to the facility when x-ray results were released. The Physician stated faxes were received on the copy machine located in the front hallway of the facility and all nurses would have had access to the machine, but not all agency nurses may have known about the fax being received. During an interview on 6/20/2025 at 4:35 PM the Administrator stated she would expect a resident to be sent to the hospital once they were notified of a fracture. The Administrator was unaware the mobile x-ray company had attempted and failed to reach the facility multiple times on 12/29/2024. The Administrator stated she would have wanted to receive the x-ray report as soon as it was available so it could be reported to the provider.	F0777		
F0803 SS = E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of	F0803	F803 Menus Meet Resident Nds/Prep in adv/followed Facility failed to follow planned menus for 3 of 3 residents reviewed for preferences. (residents #96, #3, and #111). Menus will be prepared in advance to meet the residents' needs, including appropriate portion sizes that address their nutritional requirements. The Certified Dietary Manager (CDM) obtains these menus from a food service vendor, and standardized recipes will accompany the updated menus. The menus, along with the specified portion sizes, will be reviewed and approved by the Registered Dietitian (RD) by July 22, 2025. Residents will be served portion sizes that align with the menu approved by the RD. All residents have the potential to be effective, and education will be provided by the CDM by 7/22/2025 with the dietary staff on the need to serve appropriate portion sizes as approved by the RD on the tray line.	07/22/2025

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F0803 SS = E	Continued from page 75 the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to follow their planned menus for 3 of 3 residents reviewed for preferences (Residents #96, #3, #111). The deficient practice had the potential to affect other residents who received food from the kitchen. The findings included: An interview with nursing assistant (NA) #3 on 6/18/25 at 3:15 PM revealed he had noticed residents not getting their dinner meal. He reported the kitchen had ran out of the prepared food items on the menu for the dinner meal. He stated when this happened the residents that had not received the food items on the menu got sandwiches. NA #3 reported it had happened several times although he could not remember an exact number or the exact days it happened on. He did remember it was always the dinner meal. He reported the residents would report to him they did not like getting cold sandwiches and would have preferred a hot meal. He reported the second time it happened he did make the Director of Nursing (DON) aware. An interview with a 1:1 sitter on 6/18/25 at 3:26 PM revealed she had had two occasions where the resident she was responsible for did not get the listed menu items at the dinner meal. She reported they got a sandwich instead. She stated she could not remember the specific resident this happened to, and she had seen other times where residents she was not responsible for also not get the listed menu items for dinner. She was unsure what those residents were given. She reported	F0803	Continued from page 75 Current and New dietary staff will receive education on following menus and serving the appropriate portion sizes as part of the dietary staff orientation program. The orientation program for dietary cooks and aides will include training on following menus and serving appropriate portion sizes. The orientation checklists for dietary staff will be updated by the HR director. Director to include following menus and serving appropriate portion sizes. A daily spreadsheet with the portion sizes for menu items as approved by the RD will be maintained at the tray line work area for review by the dietary staff prior to meal service and as a reference as needed while serving by 7/22/2025. CDM, or CDM designee, will complete random audits weekly x 4 or longer until substantial compliance is achieved as determined by the QAPI Committee to assess that menus approved by the RD are in use, the daily spreadsheet with portion sizes is available in the tray line work area and followed by dietary staff. The CDM or Administrator will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 7/22/2025	

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F0803 SS = E	Continued from page 76 she did make the nurse on duty aware but she could not remember which nurse it was. An interview with the Dietary Manager (DM) on 6/18/2025 at 3:50 PM revealed Cook #1 had been replaced recently due to him frequently not preparing enough of the food items on the menu despite the training he had received. She reported she was unsure if Cook #1 was not cooking enough food or if he was serving too much food, but he would frequently run out of food on the dinner meal. DM reported she had tried several times to retrain him by working with him personally during meal times, explaining how to use the recipes and census to determine how much food to cook. She reported she reviewed the serving spoons to determine how much to serve on a plate. She reported her relief cook also worked with him, but the training was not successful. DM stated she also felt Cook #1's choices in what to use to replace the menu items were not adequate, however he would not call her with questions or concerns even though she had told him to always call if he was unsure. DM reported there was always adequate food in the kitchen to prepare for the meals on the menu as well as adequate choices for substitutes. a. Resident #96 was admitted to the facility on 4/8/25. Review of quarterly Minimum Data Set (MDS) dated 6/12/25 revealed Resident #96 was cognitively intact and required only set up assistance from staff for eating. Interview with Resident #96 on 6/19/25 at 3:23 PM indicated there have been times when we didn't get what was on the menu because the kitchen ran out of food. He stated it always happened at the dinner meal. Resident #96 reported when the kitchen ran out of food for that meal they substituted with a sandwich. Resident #96 reported he had not been served the dinner meal on the menu at least three times. b. Resident #111 was admitted to the facility on 1/18/25. Review of quarterly Minimum Data Set (MDS) dated 5/25/25 indicated Resident #111 was cognitively intact and required only set up assistance from staff for eating.	F0803		

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F0803 SS = E	Continued from page 77 Interview with Resident #111 on 6/19/25 at 3:35 PM revealed she had not received the dinner meal listed on the menu on at least three different evenings. The last time being 6/16/25. She indicated she was told by staff that the kitchen had ran out of the food items on the menu and she got a sandwich instead. She reported she was not given an option to choose what kind of sandwich she preferred but also revealed she was okay with what the facility staff gave her and did not ask for anything different but would have preferred to been asked. She reported she really liked to have a hot meal for dinner. c. Resident #3 was admitted to the facility on 7/24/23. Review of quarterly Minimum Data Set (MDS) dated 5/14/25 revealed Resident #3 was cognitively intact and required only set up assistance from staff for eating. An interview with Resident #3 on 6/19/25 at 3:45 PM revealed the kitchen had ran out of the food items listed on the menu at the dinner meals three times. She reported she only got a sandwich for these meals instead of what was listed on the menu. Resident #3 indicated the most recent time the kitchen ran out of food was Monday 6/16/25. She reported she was not given a choice of what she wanted since the listed menu items were not available. She reported she would have liked to have had a hot meal instead of a cold sandwich. An interview with Cook #1 on 6/20/25 at 10:30 AM revealed he had been a dietary aide at the facility for several months and was moved into the cook position about two months ago. He stated he was "thrown" into the position without adequate training. Cook #1 indicated he was not aware of any formulas or tools that assisted him in determining how much food to cook. He reported he was told to "do something quick" in the instance he ran out of food. He reported he ran out of food several times usually during the dinner meal, although, he could not remember how many times. He stated he made the residents a sandwich to replace the menu items they did not receive. Cook #1 reported he stepped down from this position on 6/2/25. Record Review of personnel file for Cook #1 on 6/20/25 at 11:00 AM revealed he was written up for not	F0803		

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F0803 SS = E	Continued from page 78 following the menu on 5/7/25. An interview with Cook #2 revealed he had been hired as a cook on 6/2/25. Cook #2 reported his training was mostly on the job and he had learned about diets, food temps, hygiene, and looking at census to prepare meals. He reported there is no formula/recipe, and he uses his judgement on how much to cook. He stated if food items on the menu ran out he would use his own judgement of what to make for the residents who didn't get a meal. He reported he was aware residents should have a protein. He stated a meat and cheese sandwich or Peanut Butter & Jelly sandwich would be an adequate replacement meal if we run out of the listed food items on the menu. Cook #2 denied running out of listed menu items during the dinner meal on 6/19/25. An interview with Director of Nursing (DON) on 6/20/25 at 1:32 PM indicated residents get three meals a day always but did not know if the food the residents received was actually the food items listed on the menu. There were a few times that it was reported to her that the kitchen had run out of food and some residents did not get the listed menu items but were served a sandwich. She reported she knew the facility had an issue with a cook serving too much or not cooking enough food. She indicated on those days the residents did not get served what was on the menu and she was not sure what they were fed. An interview with the Administrator on 6/20/25 at 1:50 PM revealed she was aware of complaints about running out of the listed menu items during the dinner meal. She reported it was her understanding Cook #1 was either serving too big of portions or was not cooking enough. She stated she talked to Cook #1 and he let me know he did not feel comfortable in the position because he did not feel he had adequate understanding of how to prepare the food for the facility. She reported the DM and a relief cook provided one on one training with Cook #1. She reported he did well for a short time but then began to have problems with having enough food again. She reported at that time, she and the DM began looking for a new cook to fill the position and one was hired on 6/3/25. She indicated that cooks get on the job training with a senior cook. She reported there is no skills check off for this position, that the senior cook or dietary manager determines if the new employee was ready to be independent by observation of their work performance.	F0803		
F0809 SS = E	Frequency of Meals/Snacks at Bedtime	F0809	F809 Frequency of Meals/snacks	07/22/2025

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F0809 SS = E	Continued from page 79 CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observations, and resident and staff interviews, the facility failed to provide evening snacks to residents when requested for 6 of 6 residents reviewed for frequency of snacks (Residents #3, #37, #44, #96, #105 and #111). This deficient practice had the potential to affect other residents who requested evening snacks. The findings included: a. Resident #3 was admitted to the facility on 7/24/23 with diagnosis that included type 2 diabetes. A quarterly Minimum Data Set (MDS) dated 5/14/25 indicated Resident #3 was cognitively intact. An interview with Resident #3 on 6/17/25 at 11:15 AM revealed over the past six months she had been offered or received an evening snack once or twice but not on a consistent basis. She stated she believed dietary staff were supposed to restock the snack rooms at least twice a day but there were never any snacks available during	F0809	Continued from page 79 Facility failed to provide evening snacks to residents when requested for 6 of 6 residents. Resident #3, # 37, #44, #96, #105, and #111. This deficient practice had the potential to affect other residents who requested evening snacks. Starting on July 17, 2025, the Administrator and the Dietary Manager will oversee snack availability on each nursing unit by the dietary department to ensure that adequate snacks are provided. On July 17, 2025, the Dietary Manager provided training to all dietary staff regarding the snack delivery times to the nursing units and the importance of adhering to this schedule. Starting on the same date, all staff were informed about the location of the snacks and the delivery schedule from the dietary department. They were also educated on the process to follow if snacks are not found in the nourishment rooms on the nursing units, as outlined by the Staff Development Coordinator or their designee. Starting on July 17, 2025, the Administrator, Dietary Manager, or their designee will conduct audits of three snack deliveries each week. These audits will assess adherence to the availability of snacks for residents and the timing of the deliveries. The audits will be carried out over a period of 12 weeks. The results will be reviewed by the QAPI committee, and the correction plan will be revised as necessary. Date of compliance: 7/22/2025	

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F0809 SS = E	Continued from page 80 the evening shifts or anytime during the weekends. Resident #3 revealed when she would ask staff about receiving an evening snack, they would tell her there were no snacks available in the snack rooms for them to give to her and she was not aware if staff were able to get snacks from the kitchen after hours or not. b. Resident #37 was admitted to the facility on 9/07/17 with diagnosis that included type 2 diabetes and malnutrition. A quarterly MDS dated 5/27/25 indicated Resident #37 was cognitively intact. An interview with Resident #37 on 6/17/25 at 11:17 AM revealed for the past several months she had been offered or received an evening snack on a handful of occasions but not on a consistent basis. She stated she would have her family bring her snacks to keep in her room or buy them herself. Resident #37 revealed when she or other residents would ask staff about receiving an evening snack, they would tell her there were no snacks available for them to give to her. She stated the snack rooms were typically only stocked once a day during first shift and were empty during the evening shift and weekends. c. Resident #44 was admitted to the facility on 4/29/24. An annual MDS dated 4/14/25 indicated Resident #44 was cognitively intact. An interview with Resident #44 on 6/17/25 at 11:20 AM revealed during her stay at the facility she had never received an evening snack on a consistent basis. She stated when she had requested an evening snack from nursing staff, they had told her there were no snacks available, all the snacks had been passed out, they had run out of snacks for the evening, or nursing staff did not have access to the kitchen to refill their snacks. d. Resident #96 was admitted to the facility on 4/8/25 with diagnosis that included type 2 diabetes. An admission MDS dated 4/14/25 indicated Resident #96	F0809		

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F0809 SS = E	Continued from page 81 was cognitively intact. An interview with Resident#96 on 6/17/25 at 11:21 AM revealed since he had been at the facility he had never received an evening snack or been offered an evening snack consistently. He stated sometimes nursing staff would offer a snack and other times you would have to request a snack, and staff would usually come back and say they couldn't find any snacks in the snack room, or they were not able to access the kitchen for more snacks. e. Resident #105 was admitted to the facility on 3/26/24. A quarterly MDS dated 5/14/25 indicated Resident #105 was cognitively intact. An interview with Resident #105 on 6/17/25 at 11:25 AM revealed since he had been at the facility he had been offered or received an evening snack on a handful of occasions but not consistently. He stated that sometimes nursing staff would offer a snack and other times you would have to request a snack, and then staff would usually come back and say they couldn't find any snacks in the snack room, or they were not able to access the kitchen for more snacks. f. Resident #111 was admitted to the facility on 1/18/25 with diagnosis that included type 2 diabetes. A quarterly MDS dated 5/26/25 indicated Resident #111 was cognitively intact. An interview with Resident #111 on 6/17/25 at 11:27 AM revealed for the past several months she had been offered or received an evening snack on a handful of occasions but not on a consistent basis. She revealed when she or other residents would ask staff about receiving an evening snack, they would tell her there were no snacks available for them to give to her. She stated the snack rooms were typically only stocked once a day during first shift and were empty during the evening shift and weekends. An observation of nourishment rooms on 6/18/25 at 9:50	F0809		

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F0809 SS = E	Continued from page 82 AM with Dietary Manager #1 revealed the dietary staff had stocked the refrigerator the previous day with pre-made sandwiches, drinks and juice, crackers, snack cakes and soups available for residents. An interview with Nursing Assistant (NA) #6 on 6/18/25 at 10:17 AM revealed she had worked at the facility for the past two years on both first and second shift and was familiar with resident complaints of not receiving their evening snacks. She stated there had been times when she had gone to the nourishment rooms during evening and weekend shifts and there were no snacks available, no sandwiches, no drinks and dietary staff were informed of the issue. NA #6 revealed dietary staff were responsible for replenishing the nourishment rooms and she was not aware of nursing staff having access to the kitchen after hours to be able to get snacks or drinks for residents. An interview with Dietary Manager (DM) #1 on 6/18/25 at 2:50 PM revealed she had been at the facility since April 2025. DM #1 stated she was not aware of issues with no snacks being available in the nourishment rooms for residents and nursing staff not having access to snacks from the kitchen. DM #1 revealed she was not aware of dietary staff not stocking the nourishment rooms during first and second shift and on the weekends. DM #1 indicated personally stocked the nourishment room herself yesterday and informed nursing staff that it had been stocked and was available for residents. She also stated she had educated dietary staff on making sure the nourishment rooms were stocked with snacks, sandwiches, and drinks to be available for residents and staff. An interview with the Administrator on 6/20/25 at 5:45 PM revealed she expected there to always be snacks available for residents. The Administrator further revealed she was not aware of residents not having snacks available to them upon request and dietary staff should be stocking the nourishment rooms twice a day with enough snacks, sandwiches, and drinks for residents. She stated nursing staff should have notified dietary staff, nursing supervisors, or herself if there was an issue with not having evening snacks available for residents. The Administrator revealed that she orders an overabundance of snacks each month to make sure residents have a variety of options for their snacks and there was no reason why residents should not be receiving their evening snacks.	F0809		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary	F0812	F812 Food Procurement, Store/Prepare/Serve Sanitary	07/22/2025

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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
F0812 SS = E	Continued from page 83 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 by: Based on observations and staff interviews, the facility failed to remove expired food and failed to date perishable food stored for use in 1 of 1 walk-in cooler. This practice had the potential to affect food served to residents. The findings included: During the initial tour of the kitchen, with the Dietary Manager, on 6/16/25 from 9:45 AM to 10:15 am, an observation of the walk-in cooler revealed the following: a. a plastic container with cranberry thickener was opened and no date was written on the container b. a plastic container with lemon thickener was opened and no date was written on the container	F0812	Continued from page 83 How corrective action will be accomplished for those residents found to have been affected: No residents were identified to have been affected by this deficient practice. The facility failed to date opened beverage items, and food item in the walk-in cooler All items identified that were not dated were immediately thrown out . How the facility will identify other residents having the potential to be affected by the same deficient practice: This alleged deficient practice had the potential to affect food served to residents. On 6/16/2025, the dietary manager completed a full 100% audit of all identified storage areas to ensure no additional items were noted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All Dining Services employees were in-serviced beginning 7/17/2025 regarding proper procedures for labeling and dating items, along with daily cleaning expectations for the walk in cooler/freezers. A sanitation inspection will be conducted by The Facility Administrator or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 3 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service training from the Dietary Services Manager on proper procedures for labeling and dating items when received and opened, and expectations for maintaining clean refrigerators/freezers in all areas. Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x3 for any further problem resolution if needed. Completion date: 7/22/2025	

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F0812 SS = E	Continued from page 84 c. a box of blueberry muffins, resealed with plastic wrap had no date written on the container d. an opened bottle of orange flavored juice was opened and no date written on the container. An interview with the Dietary Manager on 6/18/25 at 11:30 AM revealed all food items should be sealed, labeled, and dated when stored. She stated all dietary aides should be checking food items on a regular basis and discard any items that are were not sealed, labeled, dated, or have expired immediately. An interview with the Administrator on 6/20/25 at 3:40 PM revealed all dietary staff had been educated on food storage. She stated all food should be labeled, sealed, dated, and expired foods should be discarded immediately.	F0812		
F0880 SS = E	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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are	F0880	F880 Infection Control Corrective action for affected residents. *For resident #106- On 6/18/2025 nurse #12 entered resident # 106's room to administer medication and perform tracheostomy care. Nurse #12 failed to DON PPE and failed to perform hand hygiene when gloves were removed after administering medication s via g tube. Nurse #12 verbally reeducated related to hand hygiene during tracheostomy and g tube care. Nurse #12 was verbally reeducated related to Enhanced Barrier Precaution policy. Corrective Action for Potentially Affected Residents. All current residents and staff have the potential to be affected by deficient infection control practices. On 7/17/2025, the Staff Development and Unit Manager completed Infection Control Rounds on all halls to determine if deficient practices noted related to hand hygiene and donning of appropriate PPE prior to care for residents on Enhanced Barrier Precautions. The audits identified all staff observed following infection control policy related to hand hygiene and donning/doffing PPE. The Staff Development Nurse began education with all direct care staff on hand hygiene and utilizing proper PPE for Enhanced Barrier Precautions. Systemic Changes	07/22/2025

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F0880 SS = E	Continued from page 85 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. §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, and staff interviews, the facility staff failed to implement	F0880	Continued from page 85 On 7/17/2025 the Staff Development Coordinator began education on hand hygiene and utilizing appropriate PPE for all full-time, part-time, PRN (as needed) Registered nurses, licensed practical nurse, medication aides, nursing aids and therapy department staff including agency. The Staff Development Coordinator will ensure agency staff will be educated prior to working their shift. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above identified staff who do not receive scheduled- in-service training by 7/22/2025 will not be allowed to work until training has been completed. Quality Assurance Beginning the week of 7/22/2025, the Staff Development Coordinator or designee will observe and monitor hand hygiene during wound care and donning/doffing PPE for Enhanced Barrier Precautions prior to performing care. Monitoring will include reviewing 5 residents weekly for 4 weeks then monthly x 2 months to ensure that proper hand hygiene and personal protective equipment use is occurring per facility policy. QA Reports will be presented in the monthly QAPI meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. Date of Compliance: 7/22/2025 F880 Infection Control On 6/18/2025 Nurse #14 performed a blood glucose for resident #96 with a shared glucometer stored in the medication cart. Nurse #14 did not clean the glucometer after performing blood glucose checks. On 6/18/2025 nurse #15 failed to use the second germicidal wipe for glucometer cleaning following a blood glucose on a shared glucometer for resident #10. Corrective Action for Potentially Affected Residents All current residents requiring blood glucose monitoring have the potential to be affected by deficient infection control practices. On 7/17/2025, the Staff Development and Unit Manager completed Infection Control Rounds on all halls to determine if	

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F0880 SS = E	Continued from page 86 infection control policy and procedures when Nurse #12 did not don personal protective equipment (PPE) for enhanced barrier precautions (EPB) when providing high-contact resident care activities for Resident #106 who had a gastrostomy tube (g-tube-a tube that goes into stomach), an indwelling urinary catheter, and a tracheostomy tube (a tube in the throat for breathing). The facility also failed to follow the manufacturer's instructions for cleaning and disinfection of a shared blood glucose meter between resident usage for 2 of 3 residents whose blood sugar levels were checked (Resident #96, Resident #10). Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA)-approved disinfectant in accordance with the manufacturer's instructions for disinfection of the glucometer potentially exposes residents to the spread of blood borne infections. There were 3 residents with bloodborne pathogens in the facility at the time of the investigation. This deficient practice was identified for 3 of 6 staff members observed for infection control practices (Nurse #12, Nurse #14, Nurse #15). The findings included: 1. A review of facility EBP policy dated 09/01/24 revealed EBP should be applied to include gown, gloves, and mask for high contact care activities such as dressing, bathing, transfers, changing linens, toileting, device care (urinary catheters, feeding tubes, tracheostomy), and wound care. A continuous observation of Nurse #12 on 06/18/25 at 8:13 AM during medication administration revealed Nurse #12 entered Resident #106's room to administer medications and perform tracheostomy care. Nurse #12 failed to don PPE prior to care of Resident #106. Nurse #12 also failed to perform hand hygiene when gloves were removed after administering medications via g-tube for Resident #106. Nurse #12 then donned new gloves and performed tracheostomy care. An interview with Nurse #12 on 06/18/25 at 8:41 AM stated due to nervousness, she forgot to apply PPE during medication administration and tracheostomy care of Resident #106. Nurse #12 stated she also forgot to perform hand hygiene between administration of medication via g-tube and performing tracheostomy care for Resident #106.	F0880	Continued from page 86 deficient practices noted related to blood glucose monitor disinfection for residents receiving blood glucose monitoring. The audits identified licensed nursing staff observed were following infection control policy related to blood glucose monitoring disinfection. The Staff Development Nurse began education with all licensed nursing staff on blood glucose monitoring disinfection process. Systemic Changes On 7/17/2025 the Staff Development Coordinator began education on blood glucose monitoring disinfection process for all full-time, part-time, PRN (as needed) Registered nurses, licensed practical nurse. The Staff Development Coordinator will ensure agency licensed nurses will be educated prior to working their shift. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above identified staff who do not receive scheduled- in-service training by 7/22/2025 will not be allowed to work until training has been completed. Quality Assurance Beginning the week of 7/22/2025, the Staff Development Coordinator or designee will observe and monitor blood glucose monitoring disinfection process before and after blood glucose is obtained. Monitoring will include reviewing 5 residents weekly for 4 weeks then monthly x 2 months to ensure that proper hand hygiene and personal protective equipment use is occurring per facility policy. QA Reports will be presented in the monthly QAPI meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. Date of Compliance: 7/22/2025	

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F0880 SS = E	Continued from page 87 An interview with the Infection Preventionist on 06/18/25 at 11:51 AM revealed that Nurse #12 should have donned PPE during medication administration and tracheostomy care for Resident #106 who was on EBP. The Infection Preventionist indicated that PPE would include a gown, gloves, and a mask. PPE hangs on door and is stocked regularly by the Infection Preventionist. An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM revealed Nurses were to apply PPE for high contact interactions with residents who had urinary catheters, tracheostomy, or g-tubes when medication was administered, or other care was provided. Hand hygiene should also be performed by staff before moving from one body part to another. An interview with the Administrator on 06/19/25 at 4:15 PM revealed Nurses were to apply PPE for high contact interactions with residents with catheters, tracheostomy, or g-tubes. Hand hygiene should be performed by all staff before, during, and after care. 2. A review of the glucometer manufacturer's cleaning and disinfection procedure guide revealed the glucometer should be cleaned with an Environmental Protection Act (EPA) approved germicidal wipe after use on each patient. Manufacturer instructions stated use one germicidal wipe to clean and a second wipe to disinfect. The glucometer manufacturer procedure guide indicated the germicidal disposable wipes that the facility had available on medication cart, were listed as an approved disinfectant on the manufacturer's cleaning instructions. A review of facility policy titled Glucometer Disinfection dated 10/01/24 revealed "glucometers will be cleaned and disinfected after each use and according to manufacturer instructions regardless of whether intended for single resident or multiple resident use." The procedure for glucometer disinfection stated "retrieve 2 disinfection wipes from the container. Use the first wipe to clean first to remove heavy soil, blood, or other contaminants left on the surface of the glucometer. After cleaning with the first wipe, use the second wipe to disinfect the glucometer thoroughly with the disinfectant wipe. Allow the glucometer to air dry."	F0880		

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F0880 SS = E	Continued from page 88 An observation on 06/18/25 at 12:00 PM of Nurse #14 performing a blood glucose test for Resident #96 with a shared glucometer stored in the medication cart. Nurse #14 gathered supplies (alcohol pad, disposable lancet, and test strips) for blood glucose check. Nurse #14 did not clean the glucometer prior to blood glucose check. Nurse #14 entered Resident #96's room. While wearing gloves, Nurse #14 wiped Resident #96's finger with the alcohol pad, used disposable lancet to obtain a drop of blood from her finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #14 discarded the trash and placed the disposable lancet in the sharps container. Nurse #14 obtained EPA approved germicidal wipes from the medication cart and used 1 wipe to clean the shared glucometer. Nurse #14 failed to use the second germicidal wipe to disinfect the glucometer. An interview with Nurse #14 06/18/25 at 12:05 revealed Nurse #14 only cleaned the glucometer after performing blood glucose checks. Nurse #14 stated to his knowledge, the facility policy stated to clean the shared glucometer after use. Nurse #14 stated glucometer was considered clean prior to use because it had been cleaned after the last glucometer check. An interview with the Infection Preventionist on 06/18/25 at 11:51 AM revealed that glucometers are shared and stored in medication carts. The Infection Preventionist stated glucometers should be disinfected after use with germicidal wipes should be visibly wet for at least 2 minutes. An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM revealed Nurses were to disinfect shared glucometers according to facility policy and manufacturer directions. An interview with the Administrator on 06/19/25 at 4:15 PM revealed glucometers needed to be disinfected to prevent blood borne pathogen transmission. Nurses used shared glucometers and had germicidal wipes available to cleanse and disinfect the shared glucometers after each use. 3. An observation on 06/18/25 at 3:31 PM of Nurse #15 performing a blood glucose test for Resident #10 with a	F0880		

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F0880 SS = E	Continued from page 89 shared glucometer stored in the medication cart. Germicidal wipes were observed on the medication cart. Nurse #15 gathered supplies (alcohol pad, disposable lancet, and test strips) for blood glucose check. Nurse #15 did not clean the glucometer prior to blood glucose check. Nurse #15 entered Resident #10's room. Nurse #15 wore gloves, and wiped Resident #10's finger with the alcohol pad, used disposable lancet to obtain a drop of blood from Resident #10's finger and applied the blood to the test strip inserted into the glucometer. Once the blood glucose results were obtained, Nurse #15 discarded the trash and placed the disposable lancet in the sharps container. Nurse #15 obtained EPA approved germicidal wipes from the medication cart and used 1 wipe to clean the shared glucometer. Nurse #15 scrubbed glucometer for 2 minutes using 1 germicidal wipe. Nurse #15 failed to use the second germicidal wipe. Nurse #15 then placed the glucometer on a tissue to dry. An interview on 06/18/25 at 3:36 PM Nurse #15 (agency staff) stated the glucometer was shared between residents. Nurse #15 reported the glucometer should be cleaned after blood glucose checks were performed. Nurse #15 indicated he does not clean the glucometer before use but does use the disinfectant wipes on the glucometer after each use, then placed the glucometer on a tissue to dry before stored back in medication cart. An interview with the Infection Preventionist on 06/18/25 at 11:51 AM revealed that glucometers are shared and stored in medication carts. The Infection Preventionist stated glucometers should be disinfected after use with germicidal wipes and glucometer should be visibly wet for at least 2 minutes. An interview with the Director of Nursing (DON) on 06/19/25 at 1:11 PM revealed Nurses were to disinfect shared glucometers according to facility policy and manufacturer directions. An interview with the Administrator on 06/19/25 at 4:15 PM revealed glucometers needed to be disinfected to prevent blood borne pathogen transmission. Nurses used shared glucometers and had germicidal wipes available to cleanse and disinfect the shared glucometers after each use.	F0880		