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	345197	A. BUILDING _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 10/17/22 through 10/20/22. Additional information was gathered through 10/28/22. Therefore, the exit date was changed to 10/28/22. The following intakes were investigated: NC00193194, NC00193866, NC00192337, NC00192179, NC00192832, NC0019422, and NC00194217. 16 allegations were investigated and 6 were substantiated. The following intakes resulted in immediate jeopardy: NC0019422 and NC00193866. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity of J CFR 483.12 at tag F607 at scope and severity of J CFR 483.25 at tag F684 at scope and severity of J The tags F600, F607, and F684 constituted Substandard Quality of Care. Immediate Jeopardy for F 600 and F 607 began on 08/11/22 and was removed on 10/26/22. Immediate Jeopardy for F 684 began on 9/20/22 and was removed on 10/23/22. A extended survey was conducted on 10/24/22.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F 578		11/25/22

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

Electronically Signed | 11/23/2022

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F 578	Continued From page 1 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure code status available for use was accurate for 2 of 2 residents reviewed for Advanced Directives (Resident #21	F 578	F578 Corrective action accomplished for resident #21 and Resident # 98 was completed as follows: On 10-19-22 a chart review was completed by the	

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F 578	Continued From page 2 and Resident #98). The findings included: 1. Resident #21 was admitted to the facility on 4/26/22. Review of Resident #21's electronic medical record (EMR) revealed he had an order for DO NOT resuscitate. Order dated 12/15/2021. Review of Resident #21's most recent Minimum Data Set (MDS), a quarterly assessment, dated 08/05/2022, revealed Resident #21 had severly impaired cognition. Review of Resident #21's care plan revealed he had a care plan in place for at risk for alteration in code status, the resident is a DO NOT resuscitate (DNR), revised on 8/26/2022. Review of Resident #21's hard chart, located at B hall nursing station revealed no DNR form and no order for DNR. Review of the code status book located at B hall nursing station, where all residents on B hall had their DNR forms and orders for code status, located for quick access in a code blue situation, revealed Resident #21 had no DNR form and no hard copy order for DNR. Resident #21 resided on B hall. An interview was conducted with the Assistant Director of Nursing (ADON) on 10/19/2022 at 11:46 AM. She revealed that each nursing unit had a code status book, and that book had the hard copy order for code status such as "full code" or "DNR". If the order changed, then it was	F 578	Assistant Director of Nursing, (ADON), to secure the DNR status for Resident #21 and Resident #98. Resident #21 and Resident #98 had the DNR orders confirmed by the ADON on 10-19-22. Both Resident #21 and #98 had DNR forms placed on the resident record 11-15-2022 by the nurse designee. How the facility will identify other residents having the potential to be affected by the same deficient practice. All new admissions could potentially be affected by the same alleged deficient practice. Measures put into place and systemic changes made to ensure that the alleged deficient practice does not recur includes: The DNR forms and orders were removed from use on 10-19-22 by the COVID Coordinator 100% Education was provided by the ADON to registered and licensed nursing staff on 10-19-2022 regarding the changes in process for placing the DNR forms on the resident charts and that upon admission the consent orders for a DNR has to be entered in our Point, Click, Care System and received physician verification of the order. On 10-19-2022 a 100% audit was completed by a nurse designee on resident DNR orders and DNR forms to assure that all residents had completed DNR orders and DNR forms that accurately reflects the individuals personal choice. Upon admission and readmission of all residents, the admitting nurse will confirm the residents code status and will enter this information into EMR. This admitting nurse will also notify the residents physician and confirm the order.	

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F 578	Continued From page 3 the nurse's responsibility to update the code status book and the electronic medical record (EMR) for the current code status. In the event there was no order or DNR form, then the resident became a full code. The ADON stated the order, the EMR, and the code status book must match, so there would be no confusion during a code situation. An interview was conducted with the Director of Nursing (DON) on 10/19/2022 at 12:05 PM. The DON stated that the Nurse that received the order for a resident's code status was responsible for updating the code status book when the order changed. DON revealed the process during a code situation was for the nurse to check the resident's code status in the EMR, if it said DNR, the nurse would then need to check the code status book for the DNR form, if there is no DNR form in the code status book, then the resident would be treated as a full code even if the EMR stated DNR. She stated the resident's desire for code status started on admission to the facility and the Admissions Department had the first conversation with the resident regarding their wishes for code status. The Admissions Department documented the resident's wishes, and the document was scanned into the EMR for the Nurse to know the code status. Once the resident was admitted, we have them sign a consent for code status, the consent was brought to the Nurse by the Social Worker and the Nurse obtained an order from the medical provider. The code status book would then be updated. The DON stated it was her responsibility to make sure the code status books had been updated and was correct. 2. Resident #98 was admitted to the facility on	F 578	For all new admissions, once a DNR choice is made by the resident or Responsible Party informed, an order will be received by the admitting nurse and notify the individual MD. The on call physician will write an order and will enter the order into the EMR. All newly admitted and readmitted charts will be reviewed during the IDT clinical meeting to assure that the DNR order and form is completed and accurate. Scheduled registered or licensed nursing staff will receive individual education to this process prior to accepting an assignment. Newly hired registered and licensed nursing staff will be educated upon new hire orientation. Monitoring will be completed by audits of all admission and readmissions to ensure that the code status of all residents has been obtained. The audits will be completed by the Director of Nursing weekly for 3 months and then monthly for 3 months or until a pattern of compliance has been achieved. The DON will complete a report of the DNR orders and forms on a monthly basis and present this report to the Quality Assurance and Process Improvement Committee.	

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11/10/16.

Review of a physician order located in the electronic medical record dated 05/28/20 read; Do Not Resuscitate (DNR).

Review of care plan revised on 04/23/21 read in part; Resident #98 is a DNR. The goal read; Resident #98 will not have initiated any aggressive life sustaining technology if it does not meet the goals agreed upon by the resident/family/physician ongoing through the review date. The interventions included: effectively communicate the DNR wishes by placing it in front of the chart and/or when resident must be transferred outside the facility and provide comfort measures and symptoms of palliation to allow the dying process to occur as comfortably as possible.

Review of the most recent Minimum Data Set (MDS) dated 10/02/22 indicated that Resident #98 was had severely impaired cognition.

Review of the DNR book located at Station B where Resident #98 resided revealed a physician order dated 05/06/20 that read DNR. In this same book there was a physician order dated 08/18/17 that read full code with a full code agreement dated 11/10/16.

The Assistant Director of Nursing (ADON) was interviewed on 10/19/22 at 12:01 PM. The ADON stated that the previous Unit Manager (UM) who had vacated her position about a month ago was responsible for keeping the code status books at each nursing station up to date and accurate. The ADON stated that in the event of an emergency the nursing staff were supposed to check the

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code status in the electronic medical record then go to code status book and verify the information. She stated that if there was a discrepancy at all the patient would become a full code and cardiopulmonary resuscitation (CPR) would be initiated.

The Admissions Director and Social Worker were interviewed on 10/19/22 at 12:23 PM. The Admissions Director confirmed that she obtained code status on admission and uploaded the information into the electronic medical record for the nursing staff to do their part. She added that in addition to uploading the documents she also emailed them to all department managers for informational purposes. The Social Worker stated that her only involvement in the code status process was if a resident wished to change their code status she would ensure the medical provider was aware and complete the appropriate paperwork and give that information to the nursing department.

The Director of Nursing (DON) was interviewed on 10/19/22 at 12:04 PM. The DON confirmed that the former UM was responsible for ensuring the accuracy of the code status book located at each nursing station. Since the former UM had vacated the position, she and Nurse #5 were responsible for ensuring the accuracy of the code status book, but Nurse #5 had been on vacation, and she had been busy with all the other responsibilities. The DON further stated that the Admissions Director generally obtained code status on admission and upload the documents into the electronic medical record where the nursing staff would obtain the information and obtain the proper signatures and orders from the medical providers. The DON stated that in an

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F 578	Continued From page 6 emergency the nursing staff would go to either the code status book or the electronic medical record to find the residents code status.	F 578		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and facility staff interviews, the facility failed to protect a cognitively impaired resident from physical abuse from an employee when a nurse aide (NA #5) put her hands on the resident's shoulders to get her to a seated position and slapped the resident on the side of her shoulder for 1 of 2 residents reviewed for abuse (Resident #57). NA #5 slapped Resident #57 in response to Resident #57 slapping at NA #5 resulting in Resident #57 holding her left arm as NA #5 walked away stating, "I'm not going to take this off anyone". Immediate Jeopardy began on 08/11/22 when	F 600	On 10-24-22 all staff in all departments were interviewed by members of the interdisciplinary team (IDT) that consist of the Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers (ADON), Social Worker, Activities Director, Business Office Manger, Admissions Director, Rehab Manager and Office Assistant, to determine if any other resident may have been affected and if they had observed and not reported any resident abuse. The interview included questioning whether staff members have any knowledge of resident abuse- (defined as the willful	11/25/22

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Resident #57, who had severe cognitive impairment, was physically abused by NA #5. The immediate jeopardy was removed on 10/26/22 when the facility provided and implemented an acceptable credible allegation. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective.

The findings included:

Resident #57 was admitted to the facility on 05/22/19 with diagnoses that included dementia without behaviors.

A review of Resident #57's quarterly Minimum Data Set assessment dated 05/21/22 revealed her to be severely impaired with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #57 was coded as requiring extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. She needed limited assistance with transfers, walking in the room, walking in the corridors, locomotion on and off the unit, eating, and bathing. Resident #57 was coded as having had 2 or more falls with no injury since her previous assessment.

A review of the facility's investigation completed on 08/12/22 revealed Housekeeper #1 came to the Administrator on 08/12/22 stating she had witnessed NA #5 slap Resident #5 after trying to get her to sit down for the evening meal service on 08/11/22. The facility's investigation indicated the allegation to be unsubstantiated due to Housekeeper #1's lack of knowledge regarding

infliction of injury, Address the corrective action for all residents found to have been affected by the deficient practice: unreasonable confinement, intimidation, or punishment with resulting physical harm, pain,mental anguish) and that they understand the immediate reporting requirements Administrator and the Director of Nursing (DON) in the Adminsitrator□s absence. There were no findings of unreported resident abuse. The facility acknowledges that all residents have the potential to be affected by this alleged deficient practice. Measures put into place to ensure that this deficient practice does not recur includes the following:
Education was provided to the facility staff, as well as, agency staff on 10-24-22 and was completed in person and via phone by the Administrator and the DON. This education was provided on 10-24-22. Included in the education was the definition of abuse, neglect and misappropriation of property and the need to immediately notify their supervisor of all issues related to these infractions. Supervisors must inform the Administrator or DON immediately in person by phone and immediately separate the victim from the perpetrator and that dementia residents are at increased risk of being the victim of these problems. Progressive characteristics of dementia and interventions for dealing with difficult behaviors. All department managers will conduct random questioning of assigned residents regarding abuse, neglect and misappropriation during their morning

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Resident #57's behaviors and fall risks and that NA #5 was trying to get Resident #57 to sit down for her own safety.

Review of Housekeeper #1's written statement from the investigation dated 08/12/22 read "[Resident #57] was in the dining room at around 5:30 [PM] was standing up in the dining room. [NA #5], the CNA [Certified Nursing Assistant] told [Resident #57] to sit down. [Resident #57] stated she didn't want to sit down. [NA #5] assisted [Resident #57] in sitting down. [Resident #57] reached back and slapped [NA #5]'s arm [NA #5] then slapped [Resident #57] on the arm.

During a telephone interview with Housekeeper #1 on 10/24/22 at 3:20 PM, she reported she was working on the hall where Resident #57 resided on the evening of 08/11/22. She stated she had walked into the dining room to gather trash and noticed NA #5 assisting Resident #57 in sitting down. She stated Resident #57 was telling NA #5 she did not want to sit down but eventually did and once Resident #57 sat down, she slapped NA #5. She stated NA #5 immediately slapped Resident #57 on the side of her left shoulder. Housekeeper #1 reported she heard the slap and stated she observed Resident #57 to hold her left arm. She stated NA #5 then walked out of the room and stated aloud, "I'm not going to take that off of anybody." She reported she went home, was upset about what she had witnessed, spoke with a family member who worked at the facility who told her she needed to report it and stated she reported the incident the following day to the Administrator.

During an interview with NA #5 on 10/20/22 at 3:18 PM, she reported she usually worked on the

rounding. All department managers will complete routine education of their assigned staff members on Abuse, neglect and misappropriation. Reporting requirements and appropriate interventions and tactics when redirecting difficult behaviors from residents with diagnoses of dementia was included in this education.

Monitoring will be completed by the HR Director and Administrator completing inservice training on Abuse, Neglect and Misappropriation with all new hires upon hire prior to beginning their employment. The Department managers will complete random monitoring of their assigned residents and report each morning to the Manager□s morning meeting. The Administrator will track these reports on a weekly basis x 4 weeks and then monthly x 2 months. Monthly reports will be compiled by the Administrator and reported to the monthly QAPI meeting.

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locked unit where Resident #57 resided. She stated she was aware of the allegation against her and denied slapping Resident #57. NA #5 reported she did try to encourage Resident #57 to remain seated due to her behaviors of attempting to get up and wander. She stated Resident #57 had a history of falling, so all staff had to keep a close eye on her. NA #5 reported Resident #57 had been "up and down" a lot that day and was refusing verbal requests by NA #5 to sit down and stay seated. She stated in trying to get Resident #57 to remain seated, she placed her hands on Resident #57's shoulders and stated, "Come on [Resident #57], let's sit down". NA #5 reported Resident #57 sat down and swung her hand at her so NA #5 reported she thought to herself "forget it" and walked away and told Nurse #3 about the behavior.

NA #5 provided a hands-on reenactment of the incident. During this reenactment NA #5 started by saying "[Resident #57] time to sit down for dinner". She then proceeded to walk over to the surveyor, place both her hands on top of each of the surveyor's shoulders, tapping on the left shoulder and saying, "Come on [Resident #57], let's sit down." NA #5 then reported Resident #57 sat down and slapped at her at which time, NA #5 reported thinking to herself, "forget this" and then stated she walked out of the dining room.

During an interview with Nurse #3 on 10/20/22 at 6:43 PM, she verified she was working at the time the incident occurred. She reported she was unaware about the incident until the following day when she was questioned by the Administrator. She also reported NA #5 never reported any behaviors regarding Resident #57 to her on 08/11/22.

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During an interview with the Administrator on 10/20/22 at 1:53 PM, she reported she was made aware of the allegation on 08/12/22 in the afternoon when Housekeeper #1 came to her with the previous Environmental Services Director. She stated Housekeeper #1 reported she believed she had seen NA #5 slap Resident #57, however, the Administrator reported there were inconsistencies in the slap portion of the reported allegation. She stated she immediately began an investigation into the incident and unsubstantiated the allegation based on an interview with NA #5, the inability to find anyone else to corroborate what Housekeeper #1 had reported, and Housekeeper #1's lack of knowledge regarding Resident #57, her behaviors, and fall risk.

The Administrator was notified of the immediate jeopardy on 10/24/22 at 7:30 PM

The facility provided the following Credible Allegation of immediate jeopardy removal.

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

* On 8/11/22 the facility failed to protect a resident with severe cognitive impairment from physical abuse during an interaction in the dining room.

* Housekeeper #1 reported on 8/12/22 that in the dining room, she observed Resident #57 hitting Nurse Aide #5. Housekeeper #1 also reported that she then observed Nurse Aide #5 slap Resident #57 on the arm.

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*All other residents are at risk from suffering from the deficient practice, and residents with dementia and behaviors are at increased risk for abuse.

On 10/24/22, all staff in all departments were interviewed by members of the interdisciplinary team (IDT) that consists of Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers (ADON), Social Worker, Activities Director, Business Office Manager, Admissions Director, Rehab Manager, and Office Assistant, to determine if any other resident may have been affected and if they had observed and not reported any resident abuse. The interview included questioning whether staff members have any knowledge of resident abuse - (defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) and that they understand the immediate reporting requirements to the Administrator and the Director of Nursing (DON) in the Administrator's absence.

On 10/24/22, an audit of all residents with a Brief Interview of Mental Status (BIMS) of 10 or above, was completed by the Social Worker of designee to determine if they have experienced any type of resident abuse. No concerns were found.

On 10/21/22 - 10/25/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by licensed nurses to determine if there is evidence of abuse. No concerns were found.

o Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete

0n 10/24/22, education was provided to the Administrator and DON by the Corporate Consultant, District Director of Operations, regarding the definition of abuse as defined in the abuse policy, the resident's right to be free from abuse.

On 10/24/22, after being reeducated as outlined above, education for all staff was completed in person and via phone by the Administrator and DON. The education consisted of the following:
" The definition of abuse, neglect and misappropriation of property and the need to immediately notify their supervisor of all issues related to these infractions. Supervisors must inform the Administrator or DON immediately in person by phone and immediately separate the victim from and perpetrator, and that dementia residents are at increased risk of being the victim of these problems.
" Progressive characteristics of dementia (disorientation, withdrawal, mood and personality changes, and anxiety about symptoms), clinical challenges such as identifying pain, hunger, thirst, inability to express needs/wants, and other communication related symptoms of dementia that could cause a resident to have negative behaviors
" In addition to identification of these challenges, the education focused on tactics to deal with difficult behavior such as walking away to allow for de-escalation, providing time/place orientation, using a soothing tone of voice, providing gentle tactile cueing, use of gestures, offering distractions such activities, music, or person-centered strategies (pictures, personal

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F 600	Continued From page 13 memorabilia) " Signs and symptoms of abuse in a dementia resident such as physical abnormality, withdrawal, loss of appetite, and general changes in patterns and psychosocial well-being " Identification of caregivers who appear stressed or need a break from working in the dementia environment should also be brought to the immediate attention of the supervisor This training will be provided by the Administrator or the Human Resource Director to all agency staff and new employees upon hire during orientation. All facility staff in all departments, including as-needed and agency staff, received this training on 10/24/22-10/25/22 and all staff will continue to receive the training yearly thereafter. The Administrator and Human Resource Director were notified by the Regional Director of Operations of the need to provide this training to new hires on 10/25/22. Alleged IJ removal date is 10/26/22. On 10/27/22, the credible allegation of Immediate Jeopardy removal date of 10/26/22 was validated by onsite verification through facility staff interviews. The interviewed staff across all disciplines including nursing, office, housekeeping, dietary, and therapy revealed they had received in-service training regarding spotting, identifying, and reporting abuse. The also received in-service training regarding dementia care and how to handle adverse or difficult behaviors from residents with diagnoses of dementia.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607		11/25/22

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F 607	Continued From page 14 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement their abuse policies and procedures when a housekeeper observed physical abuse of a resident by nurse aide (NA) #5 and did not immediately report the abuse to a supervisor or any member of the administrative team, failed to protect the residents by allowing NA #5 to work the remainder of that shift and the following day, failed to complete a thorough of investigation of an allegation of abuse, and failed to report the allegation of abuse to the State Agency, local law enforcement, and adult protective services within the required timeframe for 1 of 2 residents reviewed for abuse (Resident #57). Immediate jeopardy began on 08/11/22 when Housekeeper #1 failed to report abuse to her supervisor or administrative team immediately after she observed NA #5 slap Resident #57. The immediate jeopardy was removed on 10/26/22 when the facility provided and implemented an acceptable credible allegation. The facility remains out of compliance at lower	F 607	On 10-24-22 all staff in all departments were interviewed by members of the interdisciplinary team (IDT) that consist of the Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers (ADON), Social Worker, Activities Director, Business Office Manger, Admissions Director, Rehab Manager and Office Assistant, to determine if any other resident may have been affected and if they had observed and not reported any resident abuse. The interview included questioning whether staff members have any knowledge of resident abuse- (defined as the willful infliction of injury, Address the corrective action for all residents found to have been affected by the deficient practice: unreasonable confinement, intimidation, or punishment with resulting physical harm, pain,mental anguish) and that they understand the immediate reporting requirements Administrator and the Director of Nursing (DON) in the	

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F 607	Continued From page 15 scope and severity of a D (isolation with no actual harm with potential for more than minimal hard that is not immediate jeopardy) to complete education and ensure monitoring system put into place are effective. Example 1.b. below is cited at lower scope and severity of a D. The findings included: 1a. Review of the facility's policy titled "Abuse and Neglect Protocol" last revised on 06/13/21 revealed the following steps to be taken in the event potential abuse was observed: "Any staff member or personal affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense." The policy further stated, "Employees of this facility who have been accused of resident abuse shall be suspended from duty until the results of the investigation have been reviewed by the Director of Nursing/Designee or Administrator." The facility's abuse policy further stated "Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of an examination must be recorded in the resident's medical record." Regarding the investigation, the facility's policy stated "The individual conducting the investigation will, at a minimum: e. Review the completed documentation forms; f. Review the resident's medical record to determine events leading up to the incident; g. Interview the person(s) reporting the incident; h. Interview any witnesses to the incident; i. Interview the resident as medically appropriate); j. Interview the resident's attending physician as	F 607	Adminsitrator□s absence. There were no findings of unreported resident abuse. The facility acknowledges that all residents have the potential to be affected by this alleged deficient practice. Measures put into place to ensure that this deficient practice does not recur includes the following: Education was provided to the facility staff, as well as, agency staff and was completed in person and via phone by the Administrator and the DON. This education was provided on 10-24-22. Included in the education was the definition of abuse, neglect and misappropriation of property and the need to immediately notify their supervisor of all issues related to these infractions. Supervisors must inform the Administrator or DON immediately in person by phone and immediately separate the victim from the perpetrator and that dementia residents are at increased risk of being the victim of these problems. Progressive characteristics of dementia and interventions for dealing with difficult behaviors. All department managers will conduct random questioning of assigned residents regarding abuse, neglect and misappropriation during their morning rounding. All department managers will complete routine education of their assigned staff members on Abuse, neglect and misappropriation. Reporting requirements and appropriate interventions and tactics when redirecting difficult behaviors from residents with diagnoses of dementia was included in this education.	

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F 607	Continued From page 16 needed to determine the resident's current level of cognitive function and medical condition; k. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; l. Interview the resident's roommate, family members, and visitors; m. Interview other residents to whom the accused employee provides care or services; and n. Review all events leading up to the alleged incident. o. Preserve all audio and video recordings of incident, if available/applicable." Resident #57 was admitted to the facility on 05/22/19 with diagnoses that included history of falling, muscle weakness, and dementia without behaviors. A review of the facility's investigation completed on 08/12/22 revealed Housekeeper #1 came to the Administrator on 08/12/22 stating she had witnessed NA #5 slap Resident #5 after trying to get her to sit down for the evening meal service on 08/11/22. The facility's investigation indicated the allegation to be unsubstantiated due to Housekeeper #1's lack of knowledge regarding Resident #57's behaviors and fall risks and that NA #5 was trying to get Resident #57 to sit down for her own safety. There was no documented assessment of Resident #57, or any other resident NA #5 had contact with on 08/11/22. There was a lack of interviews and statements from staff and residents regarding NA #5 and any other potential abuse that may have occurred. The investigation also failed to include statements or interviews from Resident #57's family and visitors.	F 607	Monitoring will be completed by the HR Director and Administrator completing inservice training on Abuse, Neglect and Misappropriation with all new hires upon hire prior to beginning their employment. The Department managers will complete random monitoring of their assigned residents and report each morning to the Manager□s morning meeting. The Administrator will track these reports on a weekly basis x 4 weeks and then monthly x 2 months. Monthly reports will be compiled by the Administrator and reported to the monthly QAPI meeting.	

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Review of Housekeeper #1's written statement from the investigation dated 08/12/22 read; [Resident #57] was in the dining room at around 5:30 [PM] was standing up. NA #5 told [Resident #57] to sit down. [Resident #57] stated she didn't want to sit down. [NA #5] assisted [Resident #57] in sitting down. [Resident #57] reached back and slapped [NA #5]'s arm [NA #5] then slapped [Resident #57] on the arm.

An interview with Housekeeper #1 on 10/24/22 at 3:20 PM, she reported she saw NA #5 slap Resident #57 on 08/11/22 after Resident #57 slapped NA #5 around 5:30 PM. She stated she did not report the incident until the following day because she did not know she needed to. She stated once she got home from her shift, she spoke with her daughter who told her she needed to tell the Administrator what she observed. Housekeeper #1 stated she informed the Administrator the following day when she came in for her shift at 2:00 PM about the incident. She stated she had not received any training prior to the incident regarding reporting guidelines for allegations of abuse.

Review of in-service logs for Housekeeper #1 provided by the facility revealed she completed an in-service training titled Patient/Residents' Rights Abuse Neglect and Elder Justice Act Inservice in May of 2022.

During an interview with NA #5 on 10/20/22 at 3:18 PM, she reported she usually worked on the locked unit where Resident #57 resided. She stated she was aware of the allegation against her and denied slapping Resident #57. NA #5 reported she did try to encourage Resident #57 to remain seated due to her behaviors of attempting

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to get up and wander. She stated Resident #57 had a history of falling, so all staff had to keep a close eye on her. NA #5 reported Resident #57 had been "up and down" a lot that day and was refusing verbal requests by NA #5 to sit down and stay seated. She stated in trying to get Resident #57 to remain seated, she placed her hands on Resident #57's shoulders and stated, "Come on [Resident #57], let's sit down". NA #5 reported Resident #57 sat down and swung her hand at her so NA #5 reported she thought to herself "forget it" and walked away and told Nurse #3 about the behavior.

During a follow up interview with NA #5 on 10/24/22 at 4:39 PM, she verified she finished her shift on 08/11/22 which ended at 11:00 PM. She also reported she worked the following day (08/12/22) from 3:00 PM until 11:00 PM.

Review of NA #5's statement within the investigation dated 08/12/22 read "I was trying to get [Resident #57] to sit down for supper several times. One of the times [Resident #57] elbowed me. I put my hands on her shoulders to get her to sit down, that's when she elbowed me, and I walked off."

During an interview with the Director of Nursing on 10/20/22 at 10:47 AM, she reported the facility was made aware on 08/12/22 of an allegation by Housekeeper #1 that NA #5 was observed "being a little rough" with Resident #57. She reported she was not a part of the investigation and that it was completed by the Administrator. The Director of Nursing reported she believed the allegation was unsubstantiated and referred to the Administrator for further information.

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During an interview with the Administrator on 10/20/22 at 1:53 PM, she reported she was initially informed of the allegation when Housekeeper #1 came to her office with the previous Environmental Services Director on the afternoon of 08/12/22. The Administrator stated Housekeeper #1 informed her she had observed NA #5 slap Resident #57 on 08/11/22 at the dinner meal service after trying to get her to sit down. The Administrator stated she began an investigation immediately after being informed of the incident taking a statement from Housekeeper #1, NA #5, and speaking with Nurse #3. She also had the facility staff complete an in-service education on reporting guidelines and timeframes since the alleged slap occurred on 08/11/22 and was not reported until the following afternoon. The Administrator reported she asked Housekeeper #1 why she waited to report what she saw and was told that Housekeeper #1 went home, thought about the incident further and then decided she needed to report what she saw when she arrived for her shift on 08/12/22. She reported she investigated the allegation as an "incident", and indicated it was not investigated as an allegation of abuse. The Administrator reported she was able to complete the investigation before NA #5 returned to the facility for her shift on 08/12/22 and stated she unsubstantiated the allegation due to Housekeeper #1 "wavering" in her description of the incident and the Administrator's belief that Housekeeper #1 was not aware of Resident #57's care needs and behaviors. The Administrator verified she did not report the allegation to local law enforcement or adult protective services and NA #5 completed her shift on 08/11/22 until 11:00 PM.

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An interview with the Housekeeping Director at the time of the incident was attempted by telephone call due to them being out of the facility at the time of the investigation but was unsuccessful.

During an interview with Nurse #3 on 10/20/22 at 6:43 PM, she verified she was working on the hall where Resident #57 resided on 08/11/22 when the incident occurred. She reported no one came to her at any time and reported the alleged abusive behavior by NA #5 towards Resident #57. She stated any allegations of that nature should immediately be reported to her, the Director of Nursing, or the Administrator.

The Administrator was notified of the immediate jeopardy on 10/24/22 at 7:30 PM

On 10/26/22 at 5:27 PM, the facility provided the following Credible Allegation of Compliance: F607

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

On 8/11/22, the facility failed to follow the abuse policy in the areas of prevention, protection, reporting and training.

*The facility failed to implement their abuse policies and procedures for preventing, reporting, protection, and training when in the dining room, Housekeeper #1 observed Resident #57 hitting Nurse Aide #5. Housekeeper #1 also stated that she then observed Nurse Aide #5 slap Resident #57 on the arm but did not report this incident to her supervisor until the next day. The perpetrator

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continued to work her shift in the special care unit.

*All residents are at risk from suffering from the deficient practice, and residents with dementia and behaviors are at increased risk for abuse.

On 10/24/22, an audit was completed by interviewing all residents with a Brief Interview of Mental Status (BIMS) of 10 or above by social worker and designees to determine who could alert staff to instances of abuse. Residents were interviewed for unreported abuse occurrences. No other residents were identified as being abused and not reported.

On 10/21/22 - 10/25/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by licensed nurses and designees to determine if there is evidence that they have experienced any abuse, including bruises of unknown origin or other unknown skin impairments.

o 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

On 10/24/2022, all staff in all departments were interviewed by members of the interdisciplinary team (IDT) that consists of Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers (ADON), Social Worker, Activities Director, Business Office Manager, Admissions Director, Rehab Manager, and Office Assistant, to determine if any other resident may have been affected and if they had observed and not reported any abuse. No concerns identified.

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Administrator was also reeducated on all components of the facility's abuse policy and how to identify abuse on 10/24/2022 by the District Director of Operations. Education included the definition of abuse, reporting requirements, the need to identify if other cognitively impaired residents had been abused, the need to protect other cognitively impaired residents by implementing skin assessments and monitoring for psychosocial changes by qualified individuals, as well as immediately separating the victim from the alleged abuser. The administrator was also educated on the progressive characteristics of dementia (disorientation, withdrawal, mood and personality changes, and anxiety about symptoms), clinical challenges such as identifying pain, hunger, thirst, inability to express needs/wants, and other communication related symptoms of dementia that could cause a resident to have negative behaviors. In addition to identification of these challenges, the education focused on tactics to deal with difficult behavior such as walking away to allow for de-escalation, providing time/place orientation, using a soothing tone of voice, providing gentle tactile cueing, use of gestures, offering distractions such activities, music, or person-centered strategies (pictures, personal memorabilia). Identification of caregivers who appear stressed or need a break from working in the dementia environment should also be brought to the immediate attention of the supervisor. The administrator was educated that this training should be completed with all new employees during the orientation process and with all staff on a yearly basis.

On 10/24/22 and 10/25/22, after being reeducated as outlined above education for all

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staff was completed by the Administrator and DON. The education consisted of the following:
" The definition of abuse, neglect and misappropriation of property and the need to immediately notify the Administrator or DON of all issues related to these infractions. If Administrator or DON are not present in facility, supervisors must be notified, and they must inform the Administrator or DON immediately in person or by phone
" Staff members who observe situations of abuse should immediately intervene to prevent continued potential abuse to residents. The perpetrator should be removed from the situation and placed under 1:1 supervision until they can be removed from premises.
" Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing. The following information should be reported:
a. The name(s) of the resident(s) to which the abuse or suspected abuse occurred
b. The date and time that the incident occurred
c. Where the incident took place
d. The name(s) of the person(s) allegedly committing the incident, if known
e. The name(s) of any witnesses to the incident
f. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.)
g. Any other information that may be requested by management.
" Signs and symptoms of abuse in a dementia resident such as physical abnormality, withdrawal, loss of appetite, and general changes in patterns and psychosocial well-being
" The progressive characteristics of dementia (disorientation, withdrawal, mood and personality changes, and anxiety about symptoms), clinical

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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challenges such as identifying pain, hunger, thirst, inability to express needs/wants, and other communication related symptoms of dementia that could cause a resident to have negative behaviors.
" In addition to identification of these challenges, the education focused on tactics to deal with difficult behavior such as walking away to allow for de-escalation, providing time/place orientation, using a soothing tone of voice, providing gentle tactile cueing, use of gestures, offering distractions such activities, music, or person-centered strategies (pictures, personal memorabilia).
" Identification of caregivers who appear stressed or need a break from working in the dementia environment should also be brought to the immediate attention of the supervisor.

This training will be provided by the Administrator or the Human Resource Director to all agency staff and new employees upon hire during orientation. All facility staff in all departments, including as-needed and agency staff, received this training on 10/24/22-10/25/22 and all staff will continue to receive the training yearly thereafter. The Administrator and Human Resource Director were notified by the Regional Director of Operations of the need to provide this training to new hires on 10/25/22.

Alleged IJ removal date is 10/26/22.

On 10/27/22, the credible allegation of Immediate Jeopardy removal date of 10/26/22 was validated by onsite verification through facility staff interviews. The interviewed staff across all disciplines including nursing, front office, housekeeping, dietary, therapy, and

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maintenance, revealed the had all received in-service training regarding identifying and reporting allegations of abuse immediately. The facility had completed skin assessments of cognitively impaired residents and had completed interviews with cognitively intact residents.

1b. Review of the facility's policy titled "Abuse and Neglect Protocol" last revised on 06/13/21 revealed the following steps to be taken in the event potential abuse was observed: "Any staff member or personal affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense." The policy also specified reporting times, stating "If an incident of suspected abuse occurs, facility shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to the state agency. An immediate investigation will be made and a copy of the findings of such investigation will be provided to the state agency within 5 working days or as designated by state law."

During an interview with the Administrator on 10/20/22 at 1:53 PM, she reported she was informed by a staff member that NA #5 had been aggressive towards Resident #57 and had slapped her. She reported she believed the Housekeeper was not aware of Resident #57's behaviors of constantly trying to stand up and pace, along with her fall risk, and may have misinterpreted NA #5's actions. The

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F 607	Continued From page 26 Administrator stated she investigated the allegation as an "incident" and not an allegation of abuse. She also verified she did not complete an initial report to send in, to the State Agency. The Administrator stated because she investigated the allegation as an "incident" and had "resolved it", she did not believe she needed to notify the State Agency, law enforcement, or adult protective services, in writing, of the allegation.	F 607		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		11/25/22

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F 655	Continued From page 27 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a baseline care plan to include a pressure injury and the use of antipsychotic medications for 1 of 4 residents reviewed for pressure ulcers and 1 of 5 residents reviewed for unnecessary medications (Resident #63). Findings included: a. Resident #63 was readmitted to the facility on 04/04/22 with diagnosis that included a left femoral neck fracture. An admission nursing progress note dated 4/4/22 indicated resident #63 had a surgical incision to the left hip contained a dry dressing; however, it did not indicate any skin breakdown/injury to Resident #63's left heel. A nursing progress note written by Wound Care	F 655	Corrective action accomplished for those residents found to have been affected by the deficient practices: The care plan for resident #63 was reviewed and updated by the MDS Director on 10-20-22. The revisions were reviewed by the Interdisciplinary team to ensure accuracy on 10-20-22. How will the facility identify other residents that have the potential to be affected by the alleged deficient practice: The facility recognizes that all new admissions has the potential to be affected by this deficient practice. Measures put into place to ensure that the alleged deficient practice will not recur includes: All new admissions will have their documentation and charts reviewed at the next clinical meeting to ensure that the baseline careplans is accurate and complete. The findings will be	

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F 655	Continued From page 28 Nurse #1 dated 4/5/22 indicated Resident #63 had a deep tissue injury (DTI) on the left heel which measured 4.5cm (centimeters) by 3.2cm. The note further indicated the DTI to be community acquired (present on admission) and a treatment was initiated. A baseline care plan completed 04/05/22 did not include skin breakdown/injury or treatments for a deep tissue injury (DTI) on Resident #63's left heel. The April 2022 Treatment Administration Record (TAR) indicated Resident #63 had received skin prep to her left heel every shift for a DTI and heel lift boots while in bed beginning on 04/05/22. An Admission Minimum Data Set Assessment (MDS) dated 4/11/22 indicated Resident #63 was cognitively impaired for decision making. The assessment further indicated Resident #63 did not have any pressure ulcers/injuries. An interview with Nurse #2 on 10/21/22 at 8:38 PM revealed she was the nurse who completed the baseline care plan on Resident #63's readmission to the facility. Nurse #2 Indicated she had completed the baseline care plans before but was not sure if she had ever included skin conditions on the baseline care plan. An interview with the Director of Nursing (DON) on 10/20/22 at 3:16 PM revealed she expected all baseline care plans to be accurate and completed within 72 hours of an admission. b. Resident #63 was readmitted to the facility on 04/04/2022 with diagnosis that included a left femoral neck fracture.	F 655	documented on a morning clinical meeting audit form by the Director of Nursing. Inservices on the accuracy and completion of the baseline careplan with all licensed personnel was provided by the Assistant Director of Nursing on 11-16-22, 11-17-22 and 11-18-22. All licensed agency nursing will be directed to complete the training information that will be kept in the agency communication book. These books will be kept at the nurses stations and monitored for completion by the Assistant Director of Nursing. Monitoring will be completed by a daily review of the admission and readmission documentation during the morning clinical meeting. MDS Director will be responsible for completing weekly audits of the baseline care plan monitoring sheets. The monitoring sheets will be reviewed weekly x 3 months and then monthly times 3 months with the results presented to the monthly Quality Assurance and Performance Improvement Committee. Completion date	

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F 655	Continued From page 29 A hospital discharge summary dated 4/4/22 indicated Resident #63 had physician orders for Quetiapine and Risperidone by mouth (medications used to treat mental/mood disorders). A baseline care plan completed 04/05/22 indicated Resident #63 did not receive psychotropic medications. The April 2022 Medication Administration Record (MAR) indicated Resident #63 had received Quetiapine 25 mg (milligrams) daily for depression and Risperidone 0.25mg twice daily for Schizophrenia. There were no behavior or side effect monitoring initiated during the month of April. An Admission Minimum Data Set Assessment (MDS) dated 4/11/22 indicated Resident #63 was cognitively impaired for decision making. It also indicated Resident #63 received 7 days of antipsychotic medications. An interview with Nurse #2 on 10/21/22 at 8:38 PM revealed she was the nurse who completed the baseline care plan on Resident #63's readmission to the facility. Nurse #2 Indicated she had completed the baseline care plans before but did not recall ever completing the section regarding psychotropic medication usage. An interview with the Director of Nursing (DON) on 10/20/22 at 3:16 PM revealed she expected all baseline care plans to be accurate and completed within 72 hours of an admission.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		11/25/22

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F 677	Continued From page 30 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide activity of daily living care that included cleaning a resident up after he had a large bowel movement and/or vomited for 1 of 3 residents reviewed for activities of daily living (Resident #27). The findings included: Resident #27 was readmitted to the facility on 12/08/20 with diagnoses that included metabolic encephalopathy, and others. Review of a care plan updated on 07/06/22 read in part; Resident #27 has an activities of daily living performance deficit related to quadriplegia, seizure disorder, cerebral palsy, metabolic encephalopathy, aphasic, contractures, non-ambulatory, and decreased mobility and requires staff assistance to complete activity of daily living task. The goal read; Resident #27 will maintain current level of function through the review period. The interventions included: bathing with assistance of one to two staff members and personal hygiene with assistance of one to two staff members. Review of the annual Minimum Data Set (MDS) dated 08/03/22 revealed that Resident #27 was severely cognitively impaired for daily decision making and required extensive to total assistance	F 677	Address the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #27 received the ADL care needed by the assigned C N A and licensed personnel on 10-19-2022. The facility recognizes that all dependent residents have the potential to be affected by this alleged deficient practice. Measures and systemic changes put into place to ensure that this alleged deficient practice does not recur includes: Facility staffing, as well as, agency staffing received inservices on providing ADL and incontinent care was provided on 11-16-22, 11-17-22, 11-18-22. Any new scheduled agency staff will receive inservicing prior to accepting an assignment. Sensitivity training was provided by the Director of Social Services on 11-16-22, 11-17-22 and 11-18-22 to all staff. Peer to Peer rounding has been implemented to establish a shift baseline of care and encourage peer achievement. Administrative nurses will complete random rounds of facility residents to verify that care has been provided. Monitoring will be completed by the Administrative nursing reports turned in to the DON for review. The DON will review	

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F 677	Continued From page 31 with activities of daily living. An observation of Resident #27 was made on 10/19/22 at 3:21 PM. Resident #27 was resting in bed wearing a brief and was covered with a sheet. The bottom sheet on Resident #27's bed had a dried brown ring that extended from the nape of his neck and extended down to his lower legs. There was a dried light brown substance on his left forearm that extended from his wrist almost to his elbow. The top sheet also had a dried brown ring on it that extended across the sheet. Once removed Resident #27 was observed lying in a brown liquid substances with particles noted. The brief that Resident #27 had on was swollen 2-3 times the normal size due to the amount of liquid it contained. Resident #27 did not have any dried substances noted to his face or mouth and the room had a foul odor that was noted. Nurse Aide (NA) #1 was interviewed at Resident #27's bedside on 10/19/22 at 3:26 PM and confirmed that she had just came on shift and had not started her care round yet. She stated she did not get any report but was gathering her supplies and would get some assistance because after observing Resident #27's current condition stated, "he will need a bed change." An observation and interview were conducted with NA #1 and NA #2 at Resident #27's bedside on 10/19/22 at 3:37 PM. NA #2 confirmed that she cared for Resident #27 on first shift and had not given him a bath "because it was not his shower day." She stated that she rounded at 1:30 PM and removed the insert that was in Resident #27's brief and he was not wet and "certainly not in the condition" he was presently. NA #2 stated	F 677	audit the nursing reports weekly x 3 months and then monthly x 3 months or until a pattern of compliance has been established. The DON will present these reports to the monthly QAPI committee for review.	

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F 677	Continued From page 32	F 677		

that at 1:30 PM there was no brown ring on the sheet and Resident #27 had no dried vomit or feces on his arm. NA #1 and NA #2 removed the top sheet from Resident #27 and turned him onto his right side. Again, the bottom sheet had a ring of brown liquid that was dried around his shoulder area but remained wet under his buttocks. The dried brown substance was also noted on the back of Resident #27's left shoulder. NA #1 and NA #2 removed the soiled brief that Resident #27 was wearing which was full and dripping liquid as they pulled it out from under him and thew it in a trash bag. NA #2 stated Resident #27 "was not a heavy wetter" and believed the brown liquid was both feces and vomit. NA #1 and NA #2 removed the bottom sheet to reveal a large wet area on the mattress. The mattress was dark blue and where it was wet was very shiny with liquid present. NA #2 had to clean the mattress as well. NA #2 had to scrub Resident #27's left forearm to remove the dried substances as well as his left shoulder that also contained the dried brown substance. During the change Resident #27 hollered and made non-coherent noises which NA #2 stated "he generally does not do that." NA #1 and NA #2 proceeded to clean Resident #27 and his bed and placed clean sheets and dry brief on Resident #27 before exiting the room. Resident #27 was observed to calm down and appeared more relaxed after being changed.

Nurse #2 was interviewed on 10/20/22 at 3:58 PM who confirmed that she cared for Resident #27 on 10/19/22 on day shift. She stated that she had been in Resident #27's room around 1:30-2:00 PM on 10/19/22 administering his medications and she noted that he has some dried mucus on his mouth and was heavily soiled. She stated she pulled back the sheet and his brief was very

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F 677	Continued From page 33 swollen and she "could tell he needed to be changed", she stated she informed NA #2 that Resident #27 needed to be changed. She stated she did not follow up to ensure that had occurred and around 3:30 PM NA #1 approached her and stated she needed some assistance in getting Resident #27 cleaned up and his bed changed. The Director of Nursing (DON) was interviewed on 10/20/22 at 3:04 PM and stated that routine incontinent care was to be provided every two hour or sooner if needed. The DON stated that NA #2 should have immediately gone to Resident #27's room and provided the care he needed when instructed to by Nurse #2. The DON stated that the staff should also not being using the inserts on residents that could not request them and they were strictly for the few resident who would ask for them. The Administrator was interviewed on 10/20/22 at 6:39 PM and stated that she was aware of the situation and stated "it was obvious that the staff need reteaching" because Nurse #2 could have assisted at the time the need for care was discovered.	F 677		
F 684 SS=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 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.	F 684		11/25/22

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F 684	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, Medical Director #1, and Medical Director #2 interviews, the facility failed to provide necessary medical attention when staff were aware of signs and symptoms of a possible cardiac event. Medical Director #1 instructed Nurse #1 to administer a pain medication along with his regular scheduled morning medications. The resident experienced cardiac arrest and subsequently passed away. This occurred for 1 of 2 resident reviewed for death (Resident #407). Immediate jeopardy began on 9/20/2022 when Resident #407 experienced signs and symptoms of a cardiac event and necessary emergent medical interventions were not provided. The immediate jeopardy was removed on 10/23/2022 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of Level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education was in place and monitoring systems that were put into place were effective. The findings included: Resident #407 was admitted to the facility on 9/15/2022. His diagnoses included fracture of T9-T10 (T= thoracic, the area of the body between the neck and abdomen) vertebra (small bones forming the backbone), atherosclerotic (build-up of fat, cholesterol, and other substances in and on the artery walls) heart disease and pain. He was admitted for rehabilitation services.	F 684	Corrective action to address the residents found to have been affected by this alleged deficient practice included; All residents who exhibited a decline in condition at the facility and were not sent out were reviewed to assess for any possible risk of being affected by the deficient practice. An audit of all residents was completed on 10-21-22 by the Regional Director of Clinical Services . There were no current residents exhibiting cardiac symptoms. The facility recognizes that all residents who exhibited a decline at the facility and were not sent out who expired were at risk of being affected by the alleged deficient practice. Measures put into place to ensure that this alleged deficient practice does not recur includes: An audit of all residents who had expired at the facility was completed by the Regional Director of Clinical Services on 10-21-22. All facility physicians and extenders, Nurse Practitioners and physician assistants received training on 10-21-22 by the Chief Medical Officer, to include how to respond and initiate medical treatment for residents that express and exhibit signs and symptoms of a cardiac event including an assessment by provider when possible or a transfer to another level of care. Medical Practitioners hired after 10-21-22 will receive education upon hire during new hire orientation by the	

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F 684	Continued From page 35 Review of the medical record revealed Resident #407 had an order dated 9/15/2022 for full code cardiopulmonary resuscitation (CPR). Review of Resident #407's hospital discharge summary dated 9/15/2022 revealed Resident #407 had a past medical history of coronary artery disease and a past surgical history of 3 vessel coronary artery bypass grafting (CABG) and cardiac stents. He was discharged on the following blood pressure, blood thinner and pain medications: clopidogrel (blood thinner) 75 milligrams (mg) by mouth once a day, lisinopril (used to decrease blood pressure) 20mg by mouth once a day, and metoprolol succinate (used to lower blood pressure) 100mg by mouth every night at bedtime and tramadol for pain. The discharge summary indicated that Resident #407 had fallen at home and fractured his thoracic vertebra and was discharged to the facility for therapy Review of Resident #407's admission Minimum Data Set (MDS) dated 09/19/22 revealed he was moderately cognitively impaired. Resident #407 was also coded for having no pain and no oxygen therapy was used during the assessment reference period. Review of Resident #407's care plan revealed he had a care plan in place for coronary artery disease and hypertension initiated on 9/20/2022. Interventions included monitor vital signs and administer medications as ordered. A telephone interview was conducted with Nurse #1 on 10/21/2022 at 1:11 PM. Nurse #1 stated she remembered Resident #407 and recalled he had fallen at home prior to coming to the facility	F 684	physicians group Associate Director of Quality and Education. The Regional Director of Clinical Services educated the Director of Nursing on 10-21-22, to include how to respond and initiate medical treatment for residents that express and exhibit signs and symptoms of a cardiac event such as chest pain that may fell like pressure, tightness, pain squeezing or aching, pain or discomfort that spreads to the shoulder, arm, back, neck,jaw, teeth, or sometimes the upper belly, cold sweat, and nausea/vomiting, including an assessment by provider when possible or a transfer to another level of care. The nurse may act independently and send the resident to the hospital in an emergency situation. All licensed personnel including Licensed Practical nurses and registered nurses were provided the information to include: pressure , tightness, pain, squeezing, or aching pain, or discomfort that spreads to the shoulder, arm, back, neck, jaw, teeth or sometimes the upper belly, cold sweat, and nausea/vomiting, including an assessment by provider when possible or a transfer to another level of care. The nurse may act independently and send the resident to the hospital in an emergency situation. This education was completed on 10-21-22 by the Director of Nursing. Licensed nurses to include agency staff and newly hired nurses will be educated prior to accepting assignment and/or during new hire orientation. The Director of Nursing was advised by the Regional Director of Clinical Services on 10-22-22 that all staff	

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F 684	Continued From page 36 and fractured his back. Resident #407 was at the facility for therapy and had to wear a back brace when he was out of the bed. She revealed on the day Resident #407 coded (09/20/22) she had been passing medications on her hall, at approximately 9:30 AM, and the Receptionist advised her that Resident #407's family had called the facility and said that he was having difficulty breathing. Nurse #1 stated she immediately got her vital sign equipment and went to Resident #407's room where Resident #407 was on the telephone and did not appear to be in any distress. She took his vital signs, and his blood pressure was 140's over 80's, his respirations were a little high at 22, his pulse was 103 and his oxygen levels were low at 86-88%. Nurse #1 stated that Resident #407 had normal color to his skin, he was not diaphoretic and said that he felt like he couldn't breathe. He was grimacing a little bit, but was not clutching his chest, rubbing his arm or his jaw. Resident #407 told Nurse #1 that his back brace was uncomfortable. Nurse #1 stated to Resident #407 that she was going to speak to Medical Director #1 (MD) and was anything bothering him. Resident #407 stated that he had chest pressure that felt like an elephant was sitting on his chest. Nurse #1 stated she reported to Medical Director #1 and Nurse Practitioner (NP), who were both in the building, what Resident #407 had told her along with his vital signs that she had taken and the reports of having trouble breathing. She stated Medical Director #1 and NP discussed among themselves and Medical Director #1 asked her if Resident #407 had any pain medication. Nurse #1 stated she told Medical Director #1 that Resident #407 had an order for Tramadol for pain as needed. Medical Director #1 instructed Nurse #1 to give Resident #407 a	F 684	who had not been educated would need to be required to have the above inservice education prior to the start of their next scheduled shift. The Director of Nursing will be required to monitor and ensure all licensed staff receive this education by maintaining a log of education. All nurse aides and non-nursing staff to include contracted and agency staff present were educated by the Director of Nursing, ADON and nursing supervisor on 10-22-22, to continue to immediately aides and agency staff will be educated prior to accepting assignment and /or during new hire orientation. The Director of Nursing was advised by the Regional Director of Clinical Services on 10-22-22 that all staff who had not been educated would need to be required to have the above in-service education prior to the start of their next scheduled shift. The Director of Nursing will be required to monitor and ensure all licensed staff receive this education by maintaining a log of education. Monitoring will be completed by the DON/ADON designee completing an audit of the 24 hour report daily x 2 months and then monthly x 2 months. A report will be compiled by the DON/ ADON and presented to the Quality Assurance Improvement Committee monthly.	

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Tramadol and monitor him. Nurse #1 stated she asked for clarification twice from Medical Director #1 that he only wanted her to give Resident #407 a Tramadol and both times was told "yes," by Medical Director #1. She stated she told Medical Director #1 again that Resident #407 stated he felt like an elephant was sitting on his chest and again Medical Director #1 stated to give Resident #407 the Tramadol and he would see him later that day. Nurse #1 stated she heard the NP state to Medical Director #1 that this was the resident Nurse #1 was talking about, the NP was pointing at a name on the list of patients that needed to be seen that day and that instructed Medical Director #1 to go and see Resident #407. Nurse #1 stated she went back to the medication cart and got Resident #407's morning medications, and a Tramadol and administered them to Resident #407, he took them without difficulty. Nurse #1 stated that she again took Resident #407's vital signs and his respirations had come down a little bit to 21. She stated that Resident #407 told her that he felt better. He was not grimacing or sweating or complaining of pain. Nurse #1 asked Resident #407 if he could use his call light if he needed her and he said "yes," and she told him that she would be outside his room and would watch for the call light as she passed medications to other residents. Nurse #1 revealed that around 11:00 AM the Physical Therapy Assistant (PTA) and Occupational Therapy Assistant (COTA) came to her medication cart and advised her that Resident #407 had a large emesis, but they had cleaned him up and assisted him back to bed and that Resident #407 felt better after he vomited. Nurse #1 stated she had charted the emesis and about 5-10 minutes later she had finished her medication pass and passed his room, she could see that he was breathing, his color was normal,

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he was not sweating, and his call bell was next to him. She stated she went to the nursing station and was charting when a family member came to the desk at around 12:00 PM and informed her that Resident #407 would not wake up and he was cold. She immediately got up and went to Resident #407's room. Upon entering the room, she felt Resident #407's chest, he was not breathing, and she listened to his heart with a stethoscope, and she could not hear a heartbeat. She stated she left the room and the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were coming out of a room, next door to Resident #407's room. She advised them that Resident #407 did not have a heartbeat. They immediately checked his code status, obtained the crash cart, and Cardiopulmonary Resuscitation (CPR) was initiated. Code Blue (called when resident is without heartbeat) was announced overhead and 911 was called. She stated she did not see Medical Director #1 go into Resident #407's room prior to the Code blue. She did see the NP respond to the code blue and talk to the family. Nurse #1 stated Medical Director #1 called off the code blue after talking to the family in the hallway. Nurse #1 indicated that she was 100% sure that she had told both Medical Director #1 and the NP that Resident #407 had chest pain that felt like an elephant was sitting on his chest. Nurse #1 revealed if Medical Director #1 or NP had not been in the facility at the time that Resident #407 had complained of chest pain, she would have called 911 and sent him to the Emergency room to be evaluated, but she had followed her chain of command.

An interview was conducted with Nurse #2 on 10/20/2022 at 11:04 AM. Nurse #2 stated she had completed her morning medication pass on her

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residents and went to assist Nurse #1 with her medication pass on 9/20/2022. She revealed during the medication pass a Nurse Aide came and advised her and Nurse #1 that Resident #407 had chest pain. Nurse #1 went and notified the NP and Medical Director #1, who were both in the facility. Nurse #1 stated that she had received an order from Medical Director #1 to administer Resident #407's regular medications and Tramadol. Nurse #2 stated she asked Nurse #1 why they were not administering nitroglycerin (common cardiac medication) to Resident #407, because it was her understanding if someone was experiencing chest pain a nitroglycerin was usually administered. Nurse #1 told her, "The Doctor said to give tramadol and his routine medications." The routine medications and the Tramadol were administered between 10:30 AM-11:00 AM. Nurse #2 stated she was not aware of Resident #407's medical history and had not taken care of him. She stated she went back to her hall after the medication pass was completed.

An interview was conducted with the Physical Therapy Assistant (PTA) and Certified Occupational Therapy Assistant (COTA) on 10/20/2022 at 11:21 AM. The PTA stated that he and the COTA had gotten Resident #407 up for the first time since his admission for therapy on 9/20/2022 around 9:30 AM. They assisted him from laying down to sitting on the side of the bed. They applied his back brace and then Resident #407 transferred from the side of the bed to the wheelchair. He required very little assistance. Resident #407 did not complain of chest pain or shortness of breath at that time. Resident #407 was advised by the PTA that he and the COTA would be back in about an hour to assist Resident #407 back to bed. When they returned to the

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room approximately 30-45 minutes later, they observed a large amount of emesis on the floor. The PTA and COTA assisted Resident #407 back to bed, cleaned him up and positioned him for comfort. Resident #407 never complained of chest pain or shortness of breath. His color was normal, and he was not sweating. Resident #407 stated he felt better after he had vomited. The PTA and COTA notified Nurse #1 of Resident #407's emesis and she came in and took his vital signs, which were all normal.

Review of the progress notes revealed a note dated 9/20/2022 at 12:30 PM by Nurse #1, "Patient not feeling well after therapy got him up this morning for the first time." Vital signs obtained and Nurse #1 spoke with the (former) Nurse Practitioner and Medical Director #1. Received an order to give regular medications and Tramadol (non-narcotic pain reliever) for discomfort from brace and getting up. Approximately 15-20 minutes later Nurse #1 rechecked Resident #407 and he advised Nurse #1 that he was not in pain. At approximately 11:00 AM, therapy advised Nurse #1 that Resident #407 had an emesis (vomit) and they laid him back down.

Review of the progress note by the DON dated 9/20/2022 at 1:03 PM revealed, "During this shift at approximately 12 noon, called to Resident #407's room due to code blue status. Upon entering the room, resident found to be pulseless and non-breathing. CPR initiated immediately. Respirations being delivered via ambu-bag (self-inflating bag to provide positive pressure ventilation to patients who are not breathing) with high flow oxygen. NP in and aware of current situation. Family in building are aware of situation.

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CPR stopped at 12:19 PM after confirmation to stop CPR by NP. Resident pronounced dead at this time. Medical Director (Medical Director #1) in house and spoke with family regarding same."

An interview was conducted with the DON on 10/20/2022 at 3:24 P. The DON stated she remembered Resident #407 as she had admitted him to the facility on 9/15/2022. She stated she had been at a meeting when she heard code blue called over the loudspeaker, she responded to the code blue in Resident #407's room. His code status was verified, and he was a full code and CPR was initiated. The DON stated that the NP had come into the room during the code and was relaying messages from the family to the team that was performing the code blue. 911 was called and they responded but were not needed as the family decided to stop CPR. Medical Director #1spoke to the family after the code, she did not remember seeing Medical Director #1 in the room during the code. The DON stated per Nurse #1's written statement, Nurse #1 had told the MD #1 and NP that Resident #407 was experiencing chest pain that felt like an "elephant was sitting on his chest," and that Nurse #1 had heard the NP tell the MD #1 that Resident #407 was on his list of residents to be seen that day. The DON indicated that routine practice was if someone had a significant cardiac history and was experiencing chest pain, that she would immediately call for help, apply oxygen and call for an ambulance.

An interview was conducted with the ADON on 10/20/2022 at 11:12 AM and confirmed she was familiar with Resident #407. The ADON revealed she had been in a meeting in a room next to Resident #407's room on the morning of

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9/20/2022 when Nurse #1 came in the room and asked her to come to his room, that she was unable to find a pulse on Resident #407. Upon entering Resident #407's room, she observed a male visitor attempting to find a pulse on Resident #407. She stated she checked for a pulse and was not able to auscultate (hear) a pulse. She checked Resident #407's code status and he was a full code, CPR was initiated. ADON indicated that the NP was present during CPR and spoke with the family. She stated she did not see the MD #1 during CPR.

A telephone interview was conducted with Medical Director #1 on 10/21/2022 at 10:03 AM. He stated he had been the Medical Director for the facility since December 2021 through October 14, 2022. Medical Director #1 stated he made rounds at the facility once a week and had been at the facility on 9/20/2022 when Resident #407 had a cardiac arrest but had not evaluated Resident #407 prior to the code. He stated that Resident #407 was on his list to be seen that day for an admission assessment. Medical Director #1 stated he had reviewed Resident #407's medical record after the code and he had a significant cardiac history but had no cardiac notes or evaluation of his cardiac history. Medical Director #1 revealed when Nurse #1 came and told him that Resident #407 had pain, he was not the only resident that had to be seen, and that he had thought the pain was coming from the back brace and getting up with therapy. He stated, "I was not the first person that the Nurse should have reported Resident #407's pain to, there was the DON, NP, other Nurses, and Nurse Aides that she should have reported to first." Medical Director #1 stated that all the residents in a nursing home had pain and he had other

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residents to see. He revealed he could not recall the exact events of Resident #407's cardiac event, but remembered he had a back brace. Medical Director #1 revealed he could not remember if Nurse #1 had told him that Resident #407 had chest pain that felt like an elephant was sitting on his chest and had emesis but recalled back pain. He stated he did not address every pain because he had a lot to do, and he was only there once a week. Medical Director #1 further stated he saw Resident #407 during the code and after, but not before, and spoke to the family twice after the code. He revealed if he had known prior to Resident #407's cardiac arrest that he had a significant cardiac history, he would have had the nurse call 911, because there was very little he could do outside of the hospital during a cardiac arrest, there was no epinephrine (cardiac drug) in the facility to use in a code, but he would have got Emergency Medical Services (EMS) involved and sent him to the hospital.

Review of the Nurse Practitioner (NP) note dated 9/20/2022 revealed "Code Blue initiated at approximately 12:00 PM due to patient having no pulse or respirations. Facility staff performed CPR (cardio-pulmonary resuscitation) and EMS (Emergency Medical Services) were requested. After approximately 15 minutes of CPR, while family members that were present spoke with patient's responsible party via telephone, it was requested that facility staff stop CPR."

A telephone interview was conducted with the Nurse Practitioner (NP) on 10/21/2022 at 11:12 AM. The NP stated she had been the facility's Nurse Practitioner for about a year and saw residents in the facility Monday-Friday. She stated she thought she had seen Resident #407 at least

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once prior to his cardiac event on 09/20/22. She explained that upon Resident #407's admission she had briefly seen him and reconciled his medication, but it was the Medical Directors responsibility to conduct a History and Physical on Resident #407. She stated on 9/20/2022, while she and Medical Director #1 were discussing which residents had to be seen that day, Nurse #1 came into the room and advised them that Resident #407 was having chest pain, what his vital signs were and that he had just gotten up for the first time with therapy with a back brace on. The NP stated Medical Director #1 advised Nurse #1 to give him some pain medication and that he would see Resident #407 that day. She revealed she did not evaluate Resident #407 prior to his cardiac event, because she had her own list of residents to see that day and she thought Medical Director #1 was going to evaluate him. She stated she pointed to the list of resident names and to Resident #407's name, and said, "see this is the man she is talking about, you need to see him first." The NP stated she believed that Resident #407 "needed to be seen immediately and pointed to the list" of resident's names. The NP stated she left to go and see her assigned residents and responded to the code blue when it was an overhead page. The NP stated she "had wrongly assumed Medical Director #1 would go see Resident #407" first, and since they were in the building, they should have gone to Resident #407's bedside and evaluated him. The NP stated that Nurse #1 had responded appropriately to Resident #407's chest pain, by reporting it to the Medical Director #1 and NP that were in the building. The NP stated that the classic signs of a cardiac event was chest pain, diaphoresis (sweating profusely) and emesis. NP revealed these signs or symptoms could have been a side

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effect of the tramadol, but that either way, it required a bedside evaluation of the resident and listening to the resident's heart with a stethoscope.

Review of a statement the NP executed on 10/25/22 indicated that the NP was working at the facility on 09/20/22 and was familiar with Resident #407 who had been admitted to the facility for rehabilitation following a vertebral fracture. The NP confirmed she was present when Nurse #1 reported Resident #407 "was expressing that he had unspecified pain." The NP declared that Nurse #1 did not convey to her on 09/20/22 that Resident #407 had "chest pain" or pain that felt like an "elephant was sitting on his chest." The NP confirmed that she was interviewed by state surveyor on 10/21/22. During the interview with the state surveyor the NP explained it had not been conveyed that Resident #407 was complaining of "chest pain" specifically and could not offer an opinion on whether Resident #407's outcome could have been different if he would have been seen immediately. In the declaration the NP stated that Nurse #1 or other staff did not alert her to the urgency of Resident #407's pain complaints. The NP indicated no one at the facility asked for Resident #407 to be sent out to the hospital for further evaluation or treatment.

An interview was conducted with Medical Director #2, by telephone, on 10/20/2022 at 12:26 PM. The MD stated she had only been the Medical Director for a few days, and she was not familiar with Resident #407. She revealed that one of the first things that needed to be done when a resident complained of chest pain was to go and do a bedside assessment. Medical Director #2 stated she would have checked his blood

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pressure, pulse, oxygen saturation level, and description of his pain. If the resident was hemodynamically stable, then she would send the resident to the emergency room for an evaluation and if not, then provide urgent care at the bedside. Medical Director #2 further stated the best procedure was to send the resident to the emergency room for an evaluation. She stated the resident needed to be assessed well, and that it depended on the resident, their medical history, the assessment on whether to administer nitroglycerin or another pain medication.

The Administrator was notified of the immediate jeopardy (IJ) on 10/21/22 at 6:54 PM.

The facility provided the IJ removal plan:

" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 9/20/2022 at approximately 9:00am, Resident #407 complained of heaviness in chest and trouble breathing. The licensed nurse notified the medical providers that were in the facility. Pain medication was given as ordered by the medical provider. Shortly after medication given, the resident expressed that he felt better. Approximately 9:20am, the physical therapist placed the residents TLSO -Thoracis Lumbar Sacral Orthoses (Back brace) on and the resident was assisted out of bed by the physical therapist and the resident tolerated the transfer without complaints. 10:50am the licensed nurse observed that the resident had vomited. The resident was assisted back to bed by the licensed nurse and the physical therapist and the TLSO brace was

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removed. The resident was repositioned in bed with head of bed elevated and the resident's upper body and face were bathed. At approximately 11:04am, the licensed nurse left the room, and the resident was resting comfortably with no further complaints of pain or discomfort. The family came to visit at approximately 12 noon and notified the nurse that the resident would not wake up. The licensed nurse assessed the resident and determined that he was not breathing and did not have a pulse. CPR (Cardio/Pulmonary Resuscitation) was initiated by the licensed nurses and the resident subsequently passed away and pronounced at 12:19pm.

- All residents who exhibited a decline in condition at the facility and were not sent out who expired were at risk of being affected by the alleged deficient practice. An audit of all residents who had expired at the facility was completed by the Regional Director of Clinical Services at 7:44 pm. 3 other residents were identified as expiring at the facility in the 30 days prior to the incident and through today. 08/20/2022 through 10/21/2022. A review of the medical record of those residents revealed that two were hospice residents and one with general decline refusing dialysis with significant past medical history.
There are no current residents exhibiting cardiac symptoms.
This reveals no other residents have been affected by the alleged deficient practice.

" 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.

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- All facility physicians and extenders, Nurse Practitioner and physician assistants received training on 10/21/2022 by the Chief Medical Officer, to include how to respond and initiate medical treatment for residents that express and exhibit signs and symptoms of a cardiac event including an assessment by provider when possible or a transfer to another level of care. Medical Practitioners hired after 10/21/22 will receive education upon hire during new hire orientation by the physicians group Associate Director of Quality and Education.

Regional Director of Clinical Services educated the Director of Nursing on 10/21/2022, to include how to respond and initiate medical treatment for residents that express and exhibit signs and symptoms of a cardiac event such as chest pain that may feel like pressure, tightness, pain, squeezing or aching, pain or discomfort that spreads to the shoulder, arm, back, neck, jaw, teeth or sometimes the upper belly, cold sweat, and nausea/vomiting, including an assessment by provider when possible or a transfer to another level of care. The nurse may act independently and send the resident to the hospital in an emergency.

All licensed personnel including Licensed Practical nurses and registered nurses were provided the information to include Identifying signs and symptoms of a possible cardiac event such as chest pain that may feel like pressure, tightness, pain, squeezing or aching. pain or discomfort that spreads to the shoulder, arm, back, neck, jaw, teeth or sometimes the upper belly, cold sweat, and nausea/vomiting, including an assessment by provider when possible or a transfer to another level of care. The nurse may

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act independently and send the resident to the hospital in an emergency. This education was completed on 10/21/2022 by the Director of Nursing. Licensed nurses, to include agency staff and newly hired nurses will be educated prior to accepting assignment and/or during new hire orientation. The Director of Nursing was advised by the Regional Director of Clinical Services on 10/22/2022 that all staff who had not been educated would need to be required to have the above in-service education prior to the start of their next scheduled shift. The Director of Nursing will be required to monitor and ensure all licensed staff receive this education by maintaining a log of education.

All nurse aides and non-nursing staff to include contracted and agency staff present were educated by the Director of Nursing, ADON and nursing supervisor on 10/22/22, to continue to immediately report any complaints of pain or changes in condition to the licensed nurse. Contracted staff, nurse aides and agency staff will be educated prior to accepting assignment and/or during new hire orientation. The Director of Nursing was advised by the Regional Director of Clinical Services on 10/22/2022 that all staff who had not been educated would need to be required to have the above in-service education prior to the start of their next scheduled shift. The Director of Nursing will be required to monitor and ensure all licensed staff receive this education by maintaining a log of education.

Alleged date of IJ removal: 10/23/22.

Medical Practitioner interviews revealed they had been re-educated on how to appropriately respond to cardiac situations and watched a

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F 684	Continued From page 50 video again reiterating the steps to take when a resident was experiencing cardiac issues. All clinical staff and non-clinical staff verbalized understanding of signs and symptoms of residents experiencing cardiac issues. All staff were able to verbalize the signs of symptoms and who to report them to if a resident should experience them and how to respond if the appropriate medical attention was not delivered to call emergency medical services. The education sign in sheets were reviewed as well as the audits conducted to ensure no other residents were affected by the deficient practice. The facility's IJ removal date of 10/23/22 was validated.	F 684		
F 698 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, Dialysis Clinical Manager and Medical Director interviews the facility failed to obtain a physician order for a resident to receive dialysis and for the monitoring of the resident's dialysis access site and failed to have a communication system in place to communicate information between the dialysis provider and the facility for 1 of 1 resident reviewed for dialysis (Resident #31). The findings included:	F 698	Corrective action accomplished for the resident found to have been affected by the deficient practice: An order was received by the Director of Nursing (DON) and entered into the Electronic Medical Record (EMR) for resident #31 dialysis and for the monitoring of the dialysis site. The facility recognizes that all residents receiving dialysis has the potential to be effected by this alleged deficient practice.	11/25/22

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F 698	Continued From page 51 Resident #31 was admitted to the facility on 05/07/22 with diagnoses that included end stage renal disease. Review of the comprehensive significant change Minimum Data Set (MDS) dated 08/10/22 revealed that Resident #31 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #31 received dialysis during the assessment reference period. Review of a care plan updated on 10/11/22 read in part; Resident #31 needs hemodialysis three times a week due to end stage renal disease. The goal read; Resident #31 will have no signs or symptoms of complications from dialysis. The interventions included check and change dressing at access site as ordered, do not draw blood, or take blood pressure in arm with graft, monitor and report any signs of infection at access site, and monitor for signs and symptoms of bleeding at access site. Review of Resident #31's active orders revealed no order for dialysis that included frequency and no order for the monitoring of Resident #31's access site. Review of Resident #31's electronic medical record and hard copy medical record revealed no communication between the dialysis provider and the facility. An observation of Resident #31 was made on 10/17/22 at 2:50 PM. Resident #31 was resting in bed with family at bedside. There was a dressing noted to her right subclavian (upper chest area)	F 698	Measures put into place to ensure that this deficient practice does not recur includes the following: Inservices were provided to the licensed and certified personnel, as well as, the transportation aide on the reinitiated dialysis communication form and the process and procedure for ensuring the form is sent and returned for each dialysis resident. Any agency staff that is scheduled to work a shift will be educated before accepting an assignment. This inservice was provided by the Assistant Director of Nursing, (ADON), on 11-17-2022, 11-18-22, 11-21-22, 11-22,22 and 11-23-22. Upon admission all dialysis patients orders are reviewed by the admitting nurse and ADON to ensure that all appropriate orders have been obtained. In addition, all orders are reviewed with the Interdisciplinary team during the clinical meeting to ensure all orders are accurate and complete. Contact was made with the Clinical Manager at the local dialysis center by the ADON on 11-17-22 to discuss the facility procedure for ensuring communication between the dialysis clinic and the facility. An agreement was reached by the Clinical Manager of the dialysis unit and the ADON on 11-17-2022 to be sent with each dialysis resident for completion and returned following the dialysis treatment. The dialysis communication sheet will be maintained in the residents medical record and reviewed in clinical meeting to monitor for completion.	

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F 698	Continued From page 52 area that was clean, dry, and intact. The Assistant Director of Nursing (ADON) was interviewed on 10/20/22 at 12:26 PM and stated there was no formal communication paperwork that was sent with Resident #31 when she went to dialysis. She stated they communicated via phone if there were any concerns and if Resident #31 had new orders the dialysis center staff generally called the facility. An interview was conducted with Nurse #4 on 10/20/22 at 1:50 PM. Nurse #4 stated that he worked at the facility only as needed and confirmed he was caring for Resident #31. Nurse #4 stated he was not sure if Resident #31 went to dialysis or not, he thought there may be a check list that they completed before dialysis, but he was not sure and relied on the other facility staff to help him if he had a resident that went to dialysis. The Transportation Aide was interviewed on 10/20/22 at 1:53 PM. He confirmed that he transported Resident #31 to/from dialysis three times a week. He also confirmed that there was no communication paperwork that he took with Resident #31 when he transported her to dialysis. He stated he would just relay any information to the staff at the facility when he returned with Resident #31. A follow up interview was conducted with the ADON ON 10/20/22 at 1:58 PM. The ADON stated that Resident #31 went to dialysis three times a week and she relied on the Transportation Aide to relay any information from the dialysis center to the facility staff. She confirmed that the Medical Director had asked	F 698	Monitoring will be completed by the DON/ADON auditing the dialysis communication sheets 5 x week for 2 weeks then 2 x a week for 1 month and then weekly x 1 month. A report will be generated by the DON/ADON and presented to the monthly Quality Assurance Process Improvement Committee meeting.	

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her recently about Resident #31's dialysis and she could not find the information in her chart, so she had asked the Transportation Aide and he was able to tell her how often and what days Resident #31 went to dialysis.

The Director of Nursing (DON) was interviewed on 10/20/22 at 2:06 PM. The DON stated that the facility did not enter orders for dialysis that included their frequency or their days and added that they did not do any dressing changes to Resident #31's access site which was in her right subclavian area. However, the DON stated that they should be monitoring Resident #31's access site for bleeding and infection and that would require a physician order. The DON stated that at one time they had a form that they filled out and sent with the resident to dialysis, but they staff at the dialysis clinic never returned it so they just quite using them. The DON confirmed that they relied on the Transportation Aide to relay information between the dialysis center and the facility staff.

The Medical Director (MD) was interviewed on 10/20/22 at 12:38 PM. The MD stated that she had only been the MD at the facility for about 2 weeks. She stated that she had met Resident #31 and her family during her visit at the facility and explained that Resident #31 had a right subclavian line that was used to dialyze Resident #31 and stated the facility should have a protocol for monitoring the site for bleeding and infection, but she was not sure what that was. The MD stated she spoke to the ADON on her recent visit to the facility and had inquired about Resident #31's dialysis days because there was no order. The MD stated the ADON spoke to the Transportation Aide to find out the information

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F 698	Continued From page 54 and the MD stated "I thought that was odd and concerned me" because the facility should not rely on the Transportation Aide to relay medical information. The MD stated she had looked up the needed information and imagined the ADON would have entered a physician order for Resident #31's dialysis and monitoring of her access site. The Clinical Manager at the local dialysis center was interviewed on 10/21/22 at 9:54 AM. The Clinical Manager confirmed that Resident #31 came to the dialysis center three times a week and they communicated with the Transportation Aide that brought her to the clinic. She also confirmed that there was no communication sheet or book that was brought with Resident #31 when she came for treatment. The Clinical Manager stated due to Resident #31's lab work she continued to receive dialysis three times a week. She stated that Resident #31 had a right subclavian access line because she was deemed not safe for surgery to have a permanent access fistula created. The Clinical Manager also stated that the dialysis staff performed the routine dressing changes to the right subclavian line and was changed with each dialysis treatment. She added the facility staff should certainly be monitoring the access site for any bleeding or infection.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		11/25/22

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categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

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F 758	Continued From page 56 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Medical Director's interviews, the facility failed to ensure a resident was free from unnecessary medications when a resident was prescribed psychotropic medications (medication that affects the brain with mental processing and behaviors) with a diagnosis of dementia and no other mental illness related diagnosis and failed to ensure gradual dose reductions (GDR) were addressed per pharmacy recommendations when the pharmacy requested a GDR be done for a psychotropic medication in September 2022 for 1 of 5 residents reviewed for unnecessary medications (Resident #63). Findings included: Review of the transferring facilities documents for Resident #63 included the following documentation: A history and physical report dated 2/22/22 which indicated Resident #63 was being seen to excessive somnolence and included a diagnosis of dementia. Under the heading assessment and plan the document indicated Resident #63 had dementia and was awaiting a mental health consultation while on routine antipsychotic utilization with somnolence noted. The document further indicated Risperdal was added in the hospital due to delirium and will likely be considered for discontinuation pending a mental health consult. The H&P included the following orders:	F 758	Corrective action taken to address the deficient practice for resident #63 included a psychiatric telehealth visit on 10-19-22 that was conducted with the facility □s psychiatric consultant and the facility Social Work Director to review the resident□s diagnoses and need for antipsychotic medication. Immediate documentation was initiated for Resident #63. Seroquel was discontinued on 4-7-2022 as a requested medication change. Trial reduction for Risperdal 0.25m g PO. Was ordered on 10-19-2022 by the psychiatric consultant. Resident # 63 responded well to this medication change. Additionally, the psychiatric consultant also amended the diagnosis to reflect dementia diagnoses with psychotic disturbance. The facility recognizes that all residents with a dementia diagnoses have the potential of being affected by this alleged deficient practice. Measures put into place to prevent this alleged deficient practice from recurring include the following: Education was provided to the licensed and registered nursing staff on the following topics: 1) Documentation requirements for behavioral medication management. 2) Referring to the psych notes to determine medical diagnoses 3) Ensuring that medical diagnoses	

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F 758	Continued From page 57 Quetiapine 25mg daily with a start date and clinical indication for usage not listed Risperdal 0.25mg twice daily with a start date and clinical indication for usage not listed An order summary report which indicated orders active as of 3/22/22 were as follows: 2/14/22: Psychology as needed 2/14/22: Psychiatry as needed 2/14/22: Behavior and side effect for psychotropic medications monitoring every shift 2/14/22: Risperdal 0.25 mg twice daily for antipsychotics Resident #63 was admitted to the facility on 03/28/22 with diagnosis that included a left femoral neck fracture and dementia without behaviors. A review of Resident #63's physician's orders revealed the following two orders were entered by Nurse #5 on 03/28/22: Quetiapine (antipsychotic) 25mg (milligrams) by mouth daily for depression. Risperdal (antipsychotic) 0.25mg twice daily for schizophrenia. An Abnormal Involuntary Movement (AIMS- a test scored to determine the severity of tardive dyskinesia in patients prescribed antipsychotic medications) assessment was completed on 03/28/22 which indicated no abnormalities. A review of the History and Physical (H&P) dated 3/29/22 indicated Resident #63 had diagnosis that included unspecified dementia without behavioral disturbance: The note further detailed Resident #63 was to continue supportive care	F 758	matches the indication for use of medication orders Education was provided to licensed, registered and certified nursing staff on 11-22-22, 11-23-22,11-24-22,11-25-22 and 11-26-22 by the ADON/ designee. Education included recognizing and documentation of any behavioral changes. This information will include relating the diagnoses to the appropriate medication and notifying Social Work so that identified residents can be referred to psychiatric services. On 10-18, 10-25, 11-2 and 11-8 -22 the facility psychiatric consultant completed an in facility assessment for all residents that have antipsychotic diagnoses and antipsychotic medications. All residents were assessed to ensure that they had correct diagnoses. These assessments were communicated to the clinical nursing staff. MDS Coordinator Director ensured that each individual careplan accurately reflects the changes in assessment and medication recommendations. In addition, the pharmacist determined that each antipsychotic medication is addressed on a separate Gradual drug reduction sheet (GDR) to clarify the specific action for each medication. Gradual drug reduction sheets (GDR) will be based off resident behavioral changes instead of quarterly review. The residents psychiatric notes will be referenced to determine the correct medical diagnoses, pharmacy will also make sure that the medical diagnoses match the indicator s for use of specific antipsychotic medication orders. Newly hired staff will receive education during	

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F 758	Continued From page 58 and had no reported resistance to care or behavioral disturbance. The H & P did not list depression and schizophrenia as diagnoses identified by the MD. A review of the March 2022 Medication Administration Record (MAR) revealed Resident #63 received Quetiapine on 2 days and Risperdal on 3 days. There were no behavior or side effect monitoring conducted during March 2022. A review of the medical record indicated Resident #63 was discharged to the hospital on 03/30/22 with a left hip fracture and was readmitted to the facility on 04/04/22 with no changes in medication orders included. The hospital discharge summary included the following orders: Quetiapine 25mg daily with no indicator for usage listed. Risperdal 0.25mg twice daily with no indicator for usage listed. A nurse readmission note dated 04/04/22 did not indicate if a medications review was completed and orders from her previous stay remained in place. This note was entered by Nurse #5. A review of the April 2022 MAR revealed Resident #63 received Quetiapine on 3 days and was discontinued on 04/07/22. It also indicated Resident #63 received Risperdal on 26 days. There were no behavior or side effect monitoring conducted during April 2022. A history and physical dated 4/5/22 written by the MD indicated Resident #63 has dementia without behavioral disturbances and was currently on	F 758	their new hire orientation. Monitoring will be completed by the DON/ADON designee completing a weekly audit of behavioral checks and antipsychotic medication use x 2 months and then monthly x 2 months to ensure a pattern of compliance is established. The DON/ADON designee will compile a report of these audits and present to the Quality Assurance Process Improvement Committee.	

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Risperdal with no reported resistance to care or behavioral disturbances.

A progress note written by the Nurse Practitioner dated 04/07/22 indicated resident had dementia without behaviors and unspecified mood affective disorder. The note gave plans to discontinue Quetiapine and continue Risperdal.

A Pharmacy Medication Reconciliation (a form provided by pharmacy to document a medical record review and suggest corrections) dated 04/14/22 revealed the pharmacy's request to add behavioral and side effect monitoring to the MAR for Risperdal for Resident #63. The DON signed off on it on 5/3/22 and added the order to the MAR.

A review of the May 2022 MAR revealed Resident #63 received Risperdal on 31 days. There were no behavior or side effect monitoring initiated until 05/03/22. The MAR further indicated Resident exhibited a behavior of agitation or restlessness on 05/26/22 during the evening shift.

A review of nurse progress notes dated 05/26/22 did not indicate Resident #63 experienced any behaviors to clarify the behavior documented on the May MAR.

A review of the June 2022 MAR revealed Resident #63 received Risperdal on 30 days. The MAR further indicated Resident exhibited no behaviors during the month.

A review of the progress notes dated April 2022 through June 2022 written by NP indicated Resident #63 had exhibited no depressed or anxious moods.

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F 758	Continued From page 60 A review of the July 2022 MAR revealed Resident #63 received Risperdal on 31 days. The MAR further indicated Resident exhibited no behaviors during the month. A progress note dated May 2022 through July 2022 written by the SW indicated Resident #63 had not exhibited any behaviors per staff report. A review of the August 2022 MAR revealed Resident #63 received Risperdal on 31 days. The MAR further indicated Resident exhibited no behaviors during the month. A progress note dated 8/9/22 written by the MD indicated she was seen for a dementia in other diseased classified elsewhere without behavioral disturbances. The note further indicated Resident #63 would continue with supportive care and had no reported episodes of resistance to care or behavioral disturbances. A review of the September 2022 MAR revealed Resident #63 received Risperdal on 28 days. The MAR further indicated Resident exhibited no behaviors during the month.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		11/25/22

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F 761	Continued From page 61 §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 date the breathing treatment medications when the foiled pouches were opened on 2 of 5 medication carts (medication carts B-2 and 300 Hall) and failed to remove loose pills from 1 of 5 medication carts (300 Hall medication cart) reviewed for medication storage. The findings include: A review of the facility's pharmacy guide sheet titled "Medications with Shortened Expiration Dates" dated 02/11/21 revealed the following a) Albuterol Sulfate use within 7 days after opening foil pouch, b) Budesonide discard 2 weeks after opening foil pouch and c) Ipratropium Bromide and Albuterol Sulfate use within 7 days after opening foil pouch.	F 761	The corrective action completed for the deficient practice: A) On 10-19-2022 the DON/ADON removed the Albuterol Sulfate that was found unlabeled in the B-2 medication cart. B) On 10-19-2022 the DON/ADON removed and discarded the Budesonide that was found to be opened and undated in the B-2 medication cart. C) On 10-19-22 the 15 loose pill of various shapes, colors and sizes were discarded per the appropriate procedure by the DON/ ADON. On 10-19-2022 the DON/ADON performed an audit of each medication cart to check for opened undated medications, as well as, any loose pills in the medication carts. Any opened or unlabeled medications were removed from the carts and properly disposed of.	

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F 761	Continued From page 62 1. On 10/17/22 12:11 PM an inspection of medication cart B-2 was conducted along with Nurse #2. The medication cart contained: one box with the delivery date of 09/12/22 of Albuterol Sulfate Inhalation Solution (a bronchodilator) 2.5 milligrams (mg) and 3 milliliters (ml) per plastic vial. There were 2 foil pouches that were open and undated in the box. The medication cart also contained one box with the delivery date of 06/16/22 of Budesonide Inhalation Suspension (a corticosteroid) 0.5 mg and 3 ml per plastic vial. There were 2 foil pouches that were open and undated in the box. During the inspection Nurse #2 acknowledged the undated medications and stated she did not know that the identified medications needed to be used in a timely manner therefore she did not know they needed to be dated when opened. The Nurse explained that each nurse assigned to the cart was responsible for keeping the medication cart clean and orderly which included dating medications when they were opened. The Nurse did not know how long the medications were good for after opening. An interview was conducted with the Director of Nursing (DON) on 10/20/22 11:30 AM. The DON explained that it was the responsibility of the third shift nurses to clean and organize the medication carts. The DON also stated each nurse should date medications when they open them and refer to the pharmacy guide for information as to when to discard the medications. At 12:23 on 10/20/22 an interview was conducted with the Administrator who explained the third shift nurses' responsibility to clean the medication carts and look for undated and outdated medications.	F 761	The facility recognizes that all residents have the potential of being affected by this alleged deficient practice. Measures put into place to ensure that this deficient practice does not recur includes the following: On 11-21-22 the facility□s pharmacy personnel completed a 100% audit of all the facility medication carts to ensure that there were no further open, unlabeled, undated or loose medications remaining in the carts. The DON, ADON and Unit manager completed education on 11-17, 11-18-22, 11-21-22, 11-22-22, 11-23-22 , for the licensed nurses, regarding dating/labeling and removing expired medications from the medication cart and medication storage room . This education will provided to any agency nursing that is scheduled to accept a shift prior to accepting the shift. The Licensed nurses will check medication carts and medication rooms nightly to assure medications are stored properly and dated and labeled appropriately, including monitoring medications for expiration dates. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON, ADON and/or the UC□s will audit medication carts and medication rooms 5 x week for 2 weeks, then weekly for 2 months to validate that medications	

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F 761	Continued From page 63 2. a. On 10/18/22 10:47 AM an inspection of 300 Hall medication cart was conducted along with Nurse #3. The medication cart contained: a box with the delivery date of 09/28/22 of Ipratropium Bromide and Albuterol Sulfate Inhalation Solution (a combination medication that helps relax and open the airways in the lungs) 0.5 mg and 3 mg per 3 ml in each plastic vial. There were 2 open and undated foil pouches. During the inspection Nurse #3 indicated that the third shift nurses should keep the medication carts clean and orderly since they had more down time than the nurses on the day shift. An interview was conducted with the Director of Nursing (DON) on 10/20/22 11:30 AM. The DON explained that it was the responsibility of the third shift nurses to clean and organize the medication carts which included removing the loose pills from the cart. She indicated the pills could have pushed through the back thin layer of the card. The DON also stated each nurse should date medications when they open them and refer to the pharmacy legend for information as to when to discard the medications. At 12:23 on 10/20/22 an interview was conducted with the Administrator who explained the third shift nurses' responsibility to clean the medication carts and look for undated and outdated medications. b. On 10/18/22 10:47 AM an inspection of 300 Hall medication cart was conducted along with Nurse #3. The medication cart contained 15 loose pills of various shapes, colors and sizes laying in the bottom of the cart drawers. During the inspection the Nurse indicated the third shift	F 761	are properly stored, dated and labeled, and medications are not expired. The DON and/or the ADON will review the audits to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting and the audits will continue according to the discretion of the QAPI committee.	

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F 761	Continued From page 64 nurses should keep the medication carts clean and orderly since they had more down time than the nurses on the day shift. An interview was conducted with the Director of Nursing (DON) on 10/20/22 11:30 AM. The DON explained that it was the responsibility of the third shift nurses to clean and organize the medication carts. At 12:23 on 10/20/22 an interview was conducted with the Administrator who explained the third shift nurses' responsibility to clean the medication carts.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		11/25/22

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F 812	Continued From page 65 Based on observations and interviews the facility failed to remove unlabeled and undated foods from the nourishment room refrigerators (B and C Station) and failed to clean and remove rust from the inside of the microwave of the nourishment room (A Station) for 3 of 3 nourishment rooms reviewed for kitchen. The findings include: 1. On 10/17/22 11:18 AM an inspection of the A Station nourishment room was conducted accompanied by Cook #1. The microwave was dirty with several areas of food particles stuck to the inside casing and glass plate and a large rust area on the front inside casing near the door. The Cook explained that the dietary department was only responsible for putting snacks and supplements in the residents' refrigerator and removing the old snacks from the refrigerator, they were not responsible for cleaning the microwave. The Cook stated she assumed that would be done by the housekeeping department. On 10/18/22 at 11:00 AM an interview was conducted with the Housekeeper #2 and the Assistant Housekeeping Supervisor (AHS) in nourishment room Station A. The microwave remained with food stains and rust. The Housekeeper explained that she only wiped the outside of the refrigerator off and did not remove food from the refrigerators. She also stated that she was never informed that she needed to clean the microwaves therefore, she does not clean them. An interview with the AHS revealed the AHS acknowledged the condition of the microwave and stated it was nasty and should be replaced. He explained the housekeepers were supposed to clean the refrigerators daily, but he	F 812	Actions taken to correct the alleged deficient practice: 1) The microwave located on A station nourishment room was removed and replaced by the Environmental Services Director, (ESD). This task was completed on 10-18-22. 2) On 10-17-22 all items that were found to be unlabeled were disposed of by the dietary staff. 3) On 10-17-22 the unlabeled chicken dinner was disposed of by Dietary Services. The facility recognizes that all residents have the possibility of being affected by this alleged deficient practice. Measures put into place to prevent this deficient practice from recurring includes the following: Education and inservices were provided for the Dietary staff by the Certified Dietary Manager , (CDM), on 11-18-2022 and Environment Services Director, (ESD), in regard to the departmental duties regarding cleaning and checking the nourishments rooms. These inservices were conducted on 11-22-22, 11-23-22 and 11-24-22. Inservices were provided to direct-line and licensed nursing staff in regard to the process and procedures for the proper food procurement, storage and maintaining sanitary food storage of resident food items. These same inservices were provided to each Environmental service worker by the Environmental Services Director. Weekly audits of all nourishment rooms will be completed by the Environmental Director and the Dietary Department. Environmental Services new hires will receive education as part of their new hire	

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F 812	Continued From page 66 did not know about the microwaves. An interview was conducted with the Director of Nursing on 10/20/22 11:34 PM who explained it was the responsibility of the dietary department to clean the nourishment room refrigerators and that included the microwaves. During an interview with the Administrator on 10/20/22 12:24 PM she explained it was now the responsibility of the housekeeping department to clean the microwaves in the nourishment rooms. 2. On 10/17/22 11:23 AM an inspection of the B Station nourishment room was conducted accompanied by Cook #1. An observation was made of the residents' refrigerator with the following items found: 1 unlabeled and undated half consumed salad 1 unlabeled and undated meal that included an unidentifiable meat and corn that had mold spots 1 unlabeled and undated tray of mixed peppers 1 unlabeled dessert 1 dirty empty plastic container 1 unlabeled bottle of steak sauce 1 unlabeled bottle of salad dressing 1 undated dried and molded sandwich 1 unlabeled and undated open flavored water 1 unlabeled flavored water The Cook explained that the dietary department was only responsible for putting snacks and supplements in the residents' refrigerator and removing the old snacks from the refrigerator. The Cook stated she assumed that would be done by the housekeeping department. On 10/18/22 at 11:00 AM an interview was	F 812	orientation. In addition, the cleaning assignments of the nutrition rooms has been added to the individual cleaning check off list for completion. Dietary new hires will receive education during their new hire orientation. Monitoring will occur by the Dietary Manager completing weekly observations of the nourishment rooms for any unlabeled food or beverages items. The Dietary Manager will check the nourishment rooms for unlabeled food weekly x 2 months and then monthly x 2 months and compile a report and present to the monthly QAPI meeting. Environmental services will complete weekly checks for sanitation and cleanliness. The Environmental Services Director will complete weekly audits x 2 months and then monthly x 2 months and present a report to the monthly QAPI meeting.	

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F 812	Continued From page 67	F 812		

conducted with the Housekeeper #2 and the Assistant Housekeeping Supervisor (AHS) in nourishment room Station B. The Housekeeper explained that she only wiped the outside of the refrigerator off and did not remove food from the refrigerators. An interview with the AHS revealed the housekeepers should clean out the nourishment room refrigerators daily but was not sure about removing the unlabeled and undated foods from the refrigerators or how long prepared foods could stay in the refrigerators.

An interview was conducted with the Dietary District Manager on 10/18/22 2:55 PM who explained the dietary department was responsible for removing the old foods from the residents' refrigerators in the nourishment rooms, but the housekeepers were responsible for daily cleaning of the refrigerators.

During an interview with the Dietary Manager (DM) on 10/19/22 1:42 PM she explained that the dietary checks the temps of the nourishment room refrigerators and keeps them stocked with supplements and snacks every day. She continued to explain that residents' names and dates should be written on the food items put in the refrigerators and the food should not be kept any longer than 3 days. She stated the dietary department has never been responsible for cleaning out the residents' refrigerators.

An interview was conducted with the Director of Nursing on 10/20/22 11:34 PM who explained it was the responsibility of the dietary department to clean the nourishment room refrigerators and that included removing outdated, undated, and unlabeled foods from the refrigerators.

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F 812	Continued From page 68	F 812		

During an interview with the Administrator on 10/20/22 12:24 PM she explained it was now the responsibility of the housekeeping department to clean the refrigerators in the nourishment rooms and that included removing outdated, undated, and unlabeled foods.

3. An inspection of the C Station nourishment room was conducted on 10/17/22 11:30 AM accompanied by Cook #1. The observation yielded 1 unlabeled chicken dinner in the residents' refrigerator freezer. The Cook explained that the dietary department was only responsible for putting snacks and supplements in the residents' refrigerator and removing the old snacks from the refrigerator. The Cook stated she assumed that would be done by the housekeeping department.

On 10/18/22 at 11:00 AM an interview was conducted with the Housekeeper #2 and the Assistant Housekeeping Supervisor (AHS) in nourishment room Station B. The Housekeeper explained that she only wiped the outside of the refrigerator off and did not remove food from the refrigerators. An interview with the AHS revealed the housekeepers should clean out the nourishment room refrigerators daily but was not sure about removing the unlabeled and undated foods from the refrigerators or how long prepared foods could stay in the refrigerators.

An interview was conducted with the Dietary District Manager on 10/18/22 2:55 PM who explained the dietary department was responsible for removing the old foods from the residents' refrigerators in the nourishment rooms, but the housekeepers were responsible for daily cleaning of the refrigerators.

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F 812	Continued From page 69 During an interview with the Dietary Manager (DM) on 10/19/22 1:42 PM she explained that the dietary checks the temps of the nourishment room refrigerators and keeps them stocked with supplements and snacks every day. She continued to explain that residents' names and dates should be written on the food items put in the refrigerators and the food should not be kept any longer than 3 days. She stated the dietary department has never been responsible for cleaning out the residents' refrigerators. An interview was conducted with the Director of Nursing on 10/20/22 11:34 PM who explained it was the responsibility of the dietary department to clean the nourishment room refrigerators and that included removing outdated, undated, and unlabeled foods from the refrigerators. During an interview with the Administrator on 10/20/22 12:24 PM she explained it was now the responsibility of the housekeeping department to clean the refrigerators in the nourishment rooms and that included removing outdated, undated, and unlabeled foods.	F 812		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		11/25/22

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F 883	Continued From page 70 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal	F 883		

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	345197	A. BUILDING _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 71 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the Pneumococcal immunization and if residents received the Pneumococcal immunization or did not receive the Pneumococcal immunization due to medical contraindication or refusal for 5 of 5 residents reviewed for infection control (Resident #21, #31, #73, #84 and #95). The findings include: 1. Resident #21 was admitted to the facility on 12/15/21. The quarterly Minimum Data assessment dated 08/05/22 revealed Resident #21's cognition was moderately impaired, and his Pneumococcal vaccination status was not up to date, and it was not offered. A review of Resident #21's medical record revealed there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.	F 883	Corrective action that has been accomplished for those residents found to have been affected by the deficient practice: 1) For Resident #21 an educational consent form was mailed to the responsible party on 10-12-22 by the facility Receptionist. The Responsible Party (RP) was contacted by the Assistant Director of Nursing,(ADON) on 11-21-22 to inquire about their intent to consent for the influenza and pneumonia vaccines. Verbal consent was obtained for both vaccines. The ADON provided education to the RP. Vaccines were administered by the ADON per the Medical Director□s order on 11-23-22 . The consent form was placed in the resident□s chart on 11-23-2022. 2) Resident # 31 was offered and received both the influenza and pneumonia vaccines on 11-14-22. The educational consent form was signed by resident # 31 on 11-14-22. Education was completed on 11-14-22 and was provided by the ADON. A copy of the consent form was placed on the residents medical record by the ADON on 11-14-22. 3) Resident # 73 RP was contacted by the ADON on 11-21-22 to request a verbal consent for administering the pneumonia vaccine. The ADON provided educational	

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F 883	Continued From page 72 On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #21's medical record regarding the benefits or potential side effects of the Pneumococcal vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record. The ICP also stated she thought the Pneumococcal vaccine was only supposed to be offered once a year when the Influenza vaccines were offered. An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #21 or his legal representative should have been educated on the benefits or potential side effects of the Pneumococcal vaccine and the information should have been in his medical record. She continued to explain that the Pneumococcal vaccine could be given year round and it should be determined on admission. During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the Pneumococcal vaccination information should be maintained on the Resident's medical record, and the residents should be offered the vaccine series on admission then her expectation was for it to be done. 2. Resident #31 was admitted to the facility on 05/07/22. The quarterly Minimum Data Set assessment dated 08/10/22 revealed Resident #31 was cognitively intact, and her Pneumococcal	F 883	information and completed a verbal consent on 11-21-22. The pneumonia vaccine was administered on 11-23-2022 by the ADON. 4) For Resident #84 an educational consent from was discussed on 11-11-22 by the ADON. Resident #84 declined the pneumococcal vaccine on 11-11-22. The declination sheet was placed in the resident chart on 11-11-22. 5) Resident #95 received education on the pneumococcal vaccine on by the ADON. The ADON administered the pneumococcal vaccine on 11-14-2022. The consent form was placed in the residents chart by the ADON on 11-14-2022. The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Measures put into place to ensure that this alleged deficient practice doesn□t recur includes the following: Education was provided to the ADON by the Regional Nurse Consultant on 10-20-22 on the process and procedures related to administering and documenting the offering of the pneumococcal immunization. Education to the ADON on educating the resident□s and resident□s responsible parties on giving consent for receiving vaccines. The declination procedure was also reviewed with the ADON on 10-20-22. A 100% audit was completed by the ADON on 10-20-22 to determine that the facility had received a 100% response to the request for vaccine consents. Contact was made by the ADON/nurse designee on 11-21-2022 by	

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F 883	Continued From page 73 vaccination status was not up to date, and it was not offered. A review of Resident #31's medical record revealed there was no information in the medical record that the Resident or the legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination. On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #31's medical record regarding the benefits or potential side effects of the Pneumococcal vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record. The ICP also stated she thought the Pneumococcal vaccine was only supposed to be offered once a year when the Influenza vaccines were offered. An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #31 or her legal representative should have been educated on the benefits or potential side effects of the Pneumococcal vaccine and the information should have been in his medical record. She continued to explain that the Pneumococcal vaccine could be given year round and it should be determined on admission. During an interview with the Administrator on	F 883	telephone to gain consent for those not received by mail. For all new admissions the resident and / or Responsible party is educated during the admissions process. This education regarding obtaining a consent or declination for vaccines will be documented in the medical record by the admitting nurse. Education was provided to all licensed nurses, as well as, agency staff prior to accepting a shift by the ADON on 11-22-22, 11-23-22, and 11-25-22. Newly hired staff will be educated to this process during the new hire orientation. Monitoring will be accomplished by the DON/ADON completing an audit on completed pneumonia consents weekly x 2 months and monthly x 2 months to confirm that all resident have a completed consent or declination form in their chart. The DON/ADON will complete a report and present to the monthly QAPI Committee.	

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F 883	Continued From page 74	F 883		

10/20/22 at 12:14 PM she stated if the policy stated the Pneumococcal vaccination information should be maintained on the Resident's medical record, and the residents should be offered the vaccine series on admission then her expectation was for it to be done.

3. Resident #73 was admitted to the facility on 08/23/21.

The quarterly Minimum Data Set assessment dated 09/15/22 revealed Resident #73's cognition was moderately impaired, and the Pneumococcal vaccination was not up to date, and it was not offered.

A review of Resident #73's medical record revealed there was no information in the medical record that the Resident or her legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #73's medical record regarding the benefits or potential side effects of the Pneumococcal vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record. The ICP also stated she thought the Pneumococcal vaccine was only supposed to be offered once a year when the Influenza vaccines were offered.

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F 883	Continued From page 75	F 883		

An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #73 or her legal representative should have been educated on the benefits or potential side effects of the Pneumococcal vaccine and the information should have been in his medical record. She continued to explain that the Pneumococcal vaccine could be given year round and it should be determined on admission.

During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the Pneumococcal vaccination information should be maintained on the Resident's medical record, and the residents should be offered the vaccine series on admission then her expectation was for it to be done.

4. Resident #84 was admitted to the facility on 01/14/22.

The quarterly Minimum Data Set assessment dated 09/26/22 revealed Resident #84's cognition was intact and the Resident's Pneumococcal vaccination status was not up to date and the Resident was not offered the vaccine.

A review of Resident #84's medical record revealed there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

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F 883	Continued From page 76	F 883		

On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #84's medical record regarding the benefits or potential side effects of the Pneumococcal vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record. The ICP also stated she thought the Pneumococcal vaccine was only supposed to be offered once a year when the Influenza vaccines were offered.

An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #84 or his legal representative should have been educated on the benefits or potential side effects of the Pneumococcal vaccine and the information should have been in his medical record. She continued to explain that the Pneumococcal vaccine could be given year round and it should be determined on admission.

During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the Pneumococcal vaccination information should be maintained on the Resident's medical record, and the residents should be offered the vaccine series on admission then her expectation was for it to be done.

5. Resident #95 was admitted to the facility on 09/10/22.

The admission Minimum Data Set assessment dated 09/13/22 revealed Resident #95's cognition was severely impaired and the Resident's

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F 883	Continued From page 77	F 883		

Pneumococcal vaccination status was not up to date and it was not offered.

A review of Resident #95's medical record revealed there was no information in the medical record that the Resident or her legal representative was provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. There was also no documentation in the medical record that the Resident was offered, received, or declined the Pneumococcal vaccination.

On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #95's medical record regarding the benefits or potential side effects of the Pneumococcal vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record. The ICP also stated she thought the Pneumococcal vaccine was only supposed to be offered once a year when the Influenza vaccines were offered.

An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #95 or her legal representative should have been educated on the benefits or potential side effects of the Pneumococcal vaccine and the information should have been in his medical record. She continued to explain that the Pneumococcal vaccine could be given year round and it should be determined on admission.

During an interview with the Administrator on

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F 883	Continued From page 78 10/20/22 at 12:14 PM she stated if the policy stated the Pneumococcal vaccination information should be maintained on the Resident's medical record, and the residents should be offered the vaccine series on admission then her expectation was for it to be done.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19	F 887		11/25/22

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F 887	Continued From page 79 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 5 of 5 residents reviewed for infection control (Resident #21, Resident #31, Resident #73, Resident #84, and	F 887	Corrective action accomplished for the residents found to have been affected by the deficient practice includes the following: 1) Resident #21 had the signed consent placed in his medical record on 10-20-22 by the COVID nurse coordinator. This	

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F 887	Continued From page 80 Resident #95). The findings included: 1. Resident #1 was admitted to the facility on 12/15/21. A review of Resident #21's medical record revealed there was no information documented in the Resident's medical record that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 vaccine. On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #21's medical record regarding the benefits or potential side effects of the COVID vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record. An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #21 or legal representative should have been educated on the benefits or potential side effects of the COVID-19 vaccine and the information should have been in the medical record. During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the COVID-19 vaccination information should be maintained on the Resident's medical record, then her expectation was for it to be done. 2. Resident #31 was admitted to the facility on	F 887	information documents the resident education, consent and dates of vaccination of the COVID vaccine. 2) Resident #31 had the signed consent placed the resident medical record on 10-20-22 by the COVID nurse coordinator. This information documents the resident□s education received, consent and dates of the vaccination of the COVID vaccine. 3) For resident # 73 the signed education and consent form was placed in the resident medical record on 10-20-22 by the COVID nurse coordinator. This information documents the resident□s education received and the vaccines administered. 4) Resident #84 had the signed declination form placed in the resident medical record on 10-20-22 by the COVID nurse coordinator. This information documents the resident's education that was received, right to decline and the dates of the declination as per resident's rights. The facility recognizes that the all residents have the potential to be affected by this alleged deficient practice. 5) For resident #95 the COVID information form and consent was placed in the resident's chart on 10-20-22 by the ADON. Measures put into place to prevent this alleged deficient practice does not recur includes: Education was provided to the DON/ADON on the proper documentation of COVID vaccines being placed in the resident's medical record. The COVID vaccine status of all newly admitted	

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F 887	Continued From page 81 05/07/22. A review of Resident #31's medical record revealed there was no information documented in the Resident's medical record that the Resident or legal representative was provided information of the benefits or potential side effects of the COVID-19 vaccine. On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #31's medical record regarding the benefits or potential side effects of the COVID vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record. An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #31 or legal representative should have been educated on the benefits or potential side effects of the COVID-19 vaccine and the information should have been in the medical record. During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the COVID-19 vaccination information should be maintained on the Resident's medical record, then her expectation was for it to be done. 3. Resident #73 was admitted to the facility on 08/23/21. A review of Resident #73's medical record revealed there was no information documented in the Resident's medical record that the Resident	F 887	residents will be ascertained upon admission. Documentation of COVID vaccines administered will be included in the admission paperwork for new residents. A 100% chart audit was completed on 10-20-22 by the COVID Nurse Coordinator to determine that all residents consents or declinations were placed in the residents charts. The Assistant Director of Nursing is responsible for ensuring the education and consents for COVID vaccines are entered into the medical record. All licensed and registered nursing staff were educated to this process on 11-23-22 by the Assistant Director of Nursing. Monitoring will be completed by the ADON/ COVID nurse coordinator completing weekly audits of all newly admitted residents to ensure that proper documentation has been placed in the residents record. The weekly audits will continue x 2 by the ADON/designee for two months and then monthly for 2 months. Reports will presented to the monthly QAPI committee for any needed revision.	

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F 887	Continued From page 82	F 887		

or legal representative was provided information of the benefits or potential side effects of the COVID-19 vaccine.

On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #73's medical record regarding the benefits or potential side effects of the COVID vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record.

An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #73 or legal representative should have been educated on the benefits or potential side effects of the COVID-19 vaccine and the information should have been in the medical record.

During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the COVID-19 vaccination information should be maintained on the Resident's medical record, then her expectation was for it to be done.

4. Resident #84 was admitted to the facility on 01/14/22.

A review of Resident #84's medical record revealed there was no documentation in the Resident's medical record that the Resident or legal representative was provided information of the benefits and potential side effects of the COVID-19 vaccine.

On 10/19/22 at 8:28 AM during an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 887	Continued From page 83	F 887		

the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #84's medical record regarding the benefits or potential side effects of the COVID vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record.

An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #84 or the legal representative should have been educated on the benefits or potential side effects of the COVID-19 vaccine and the information should have been in the medical record.

During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the COVID-19 vaccination information should be maintained on the Resident's medical record, then her expectation was for it to be done.

5. Resident #95 was admitted to the facility on 09/10/22.

A review of Resident #95's medical record revealed there was no documentation in the medical record that the Resident or legal representative was provided information of the benefits and potential side effects of the COVID-19 vaccine.

On 10/19/22 at 8:28 AM during an interview with the Infection Control Preventionist (ICP), stated she has been the ICP since December 2020, and acknowledged that there was no information in Resident #95's medical record regarding the benefits or potential side effects of the COVID

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 887	Continued From page 84	F 887		

vaccine. The ICP stated she did not know that the facility was required to maintain the information in the Resident's medical record.

An interview was conducted with the Director of Nursing (DON) on 10/20/22 at 11:17 AM. The DON explained that Resident #95 or legal representative should have been educated on the benefits or potential side effects of the COVID-19 vaccine and the information should have been in the medical record.

During an interview with the Administrator on 10/20/22 at 12:14 PM she stated if the policy stated the COVID-19 vaccination information should be maintained on the Resident's medical record, then her expectation was for it to be done.