STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELLIA GARDENS CENTER FOR NURSING AND REHAB	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		7/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/24/2023

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

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain up-to-date emergency contact information, agreements for evacuation transport and use of alternate facilities in the Emergency Preparedness Plan dated 4/23/2023. This failure had the potential to affect all staff and residents. Findings included: The facility's Emergency Preparedness Plan (EPP) was reviewed on 4/23/2023 by the Administrator. The facility's recertification and complaint investigation survey began on 6/26/2023. a. The EPP included the name of the former Administrator and contact information on the facility profile form and the rapid response guide form in the EPP. b. The EPP listed alternate facility #1 as Accordius Health at Rose Manor and alternate facility #2 as Accordius Health at Wilson. There were no agreements for evacuation transport in the EPP for Accordius Health at Rose Manor and Accordius Health at Wilson.	E 001	On 7/6/2023 the Administrator reviewed and updated the contact information, agreements for evacuation transport and use of alternate facilities in the emergency preparedness plan. On 07/10/2023 the Administrator reviewed 100% of the emergency preparedness book to ensure all items were up to date. Administrator is no longer employed by the facility as of 7/25/23. On 7/25/2023 the Chief Clinical Officer reviewed and updated the contact information, agreements for evacuation transport and use of alternate facilities in the emergency preparedness plan. On 07/25/2023 the new Administrator was educated by the Chief Clinical Officer for the Alliance Group on ensuring the contact information, agreements for evacuation transport and use of alternate facilities in the emergency preparedness plan is kept up to date and reviewed annually and with changes in plan to ensure information is kept up to date and accurate. The Chief Clinical Officer will audit the emergency preparedness plan monthly x	

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E 001	Continued From page 2 c. There were no EPP agreements for the use of alternate facilities prior to the beginning of the recertification and complaint survey. The three EPP agreements for use of alternate facilities were signed by the Administrator on 6/26/2023 and included the following facilities: Harmony Park, Pine Acres and Scotland Manor. In an interview with the Chief Regional Executive on 6/29/2023 at 6:53 a.m., she stated it was the responsibility of the Administrator to keep the EPP information up to date. In an interview with the Administrator on 6/29/2023 at 6:54 p.m., she stated EPP information needed to be kept updated.	E 001	3 months beginning 07/25/2023. Audits will be documented on the emergency preparedness monitoring log to ensure emergency contact information, agreements for evacuation transport and use of alternate facilities in the emergency preparedness plan. The Emergency Preparedness log will be brought to the Monthly Quality Assurance and Performance Improvement Committee x 3 months by the Administrator or designee for review. Any further action needed will be implemented by the committee as required. Completion date is 7/25/2023	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/26/2023 through 6/29/2023. Event ID #9NRC11. The following intakes were investigated NC00196331, NC00198250, NC00203249, NC00203776 and NC00203901. 3 of the 20 complaint allegations resulted in deficiency. The Statement of Deficiencies was amended on 08/10/23 at tag F644.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		7/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 554	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, the facility failed to assess the capability of a resident to self-administer medications kept at the bedside for 1 of 1 resident reviewed for self-administration of medications (Resident # 29). Findings included: Resident #29 was admitted to the facility on 5/6/2019, and diagnoses included stroke and glaucoma. A review of the physician orders Included: Timolol Maleate Solution 0.5% instill one drop in both eyes two times a day for glaucoma ordered on 3/17/2021, Miralax Powder 17 grams twice a day for constipation ordered on 8/24/2021 and Tobramycin-Dexamethasone Ophthalmic Suspension 0.3-0.1% (an eye antibiotic) instill one drop in both eyes for times a day for eye infection ordered on 5/4/2023. There was no physician order for Resident #29 to self-administer medications to himself. The annual Minimum Data Set (MDS) assessment dated 4/4/2023 indicated Resident #29 was cognitively intact, rejected care and received the following medications during the 7-day look back period: anticoagulants, opioids and diuretics. Resident #29's care plan dated 5/2/2023 for resistance to care indicated Resident #29 refused his medications at times and electronically ordered over-the-counter medications without making the nursing staff and the physician aware.	F 554	On 7/24/2023 Resident # 29 was assessed by nurse for self-administration of medications kept at bedside. On 7/24/2023 medications at bedside were placed in lock box by Director of Nursing. On 7/24/2023 100% of residents that are alert/oriented and physically capable were interviewed by the social worker regarding self-administration of medication. All residents wishing to self-administer medication were assessed by the Director of Nursing or designee for capability of self-administration on 7/24/2023. On 7/24/2023 100% of nurses and medication aides were re-educated on resident self-administration of medication procedure. The Director of Nursing (DON) or designee will audit 100% residents desiring to self-administer medication for capability of self-administration medications upon admission, quarterly and with changes in condition for clinical appropriateness to self-administer medications. The Director of Nursing or designee will audit residents self-administering medication for proper storage of medications at bedside weekly x 3 months beginning 07/25/2023. The audit results will be brought to monthly Quality Assurance and Performance Improvement Committee x 3 months by the DON or designee for	

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F 554	Continued From page 4 Interventions included administering medication as physician ordered. There was no care plan for Resident #29 to perform self-administration of medications. Nursing documentation dated 5/2/2023 stated Resident #29 refused Timolol eye drops and Resident #29 stated he had his own eye drops in his room that was the brand his physician recommended, and he didn't want the generic eye drops from the facility. Nursing documented also indicated on 5/26/2023 Resident #29 refused his meds and recorded Resident #29 had his own personal over-the-counter supply of medications. There was no Self Administration Assessment recorded in Resident #29's electronic medical record. On 6/26/2023 at 11:52 a.m. in an interview with Resident #29, he explained one of his eye drops was ordered every six hours, and the nursing staff had given him a bottle of eyes drops (Tobramycin) for him to self-administer. A bottle of Tobramycin eye drops was observed in a small gray bag to the left of Resident #29's bed. A small bottle of Timodol eye drops was observed on the bedside table. He stated he was able to instill his eye drops but sometimes he missed the eye. On 6/28/2023 at 7:11 a.m. while observing a medication pass with Nurse #3, Resident #29 refused ClearLax (a generic form of Miralax, a laxative) Nurse #3 attempted to administer and stated that was not Miralax, and he had his own Miralax. A bottle of Miralax was observed in Resident #29's bedside cabinet. On 6/28/2023 at 7:25 a.m. in an interview with	F 554	review. Any further action needed will be implemented by the committee as required. Completion Date 7/25/2023	

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F 554	Continued From page 5 Nurse #3, he stated Resident #29 always receiving boxes from outside the facility. He stated Resident #29 verbally aggressive with staff if staff attempted to remove the Miralax from his room. On 6/29/2023 at 2:36 p.m. in an interview with Nurse #4, she stated Resident #29 insisted on administering his own eye drops located in his room and had observed Resident #29 self-administer his eye drops. She explained Resident #29 needed a self-administration of medication assessment completed to self-administer medications and unsure if Resident #29 had been assessed for self-administration of the medications. On 6/29/2023 at 2:44 p.m. in an interview with the Director of Nursing, she explained Resident #29 was care planned for ordering over-the-counter medications because he was having over -the -counter medications shipped to the facility, and the facility could not open his mail. She stated she was not aware there were bottles of eye drops (Tobramycin and Timolol) in his room and stated Resident #29 would have received the bottles of eye drops from the nursing staff. She explained based on their policy Resident #29 needed a self-administration assessment to self-administer medications, and Resident #29 did not have a self-administration assessment or physician order to self-administer any medications.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable	F 558		7/25/23

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F 558 Continued From page 6
accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and staff interviews, the facility failed to place a resident's call light within reach to allow for the resident to request assistance if needed for 2 of 5 residents reviewed for accommodation of needs. (Resident #12 and Resident #40)

Findings included:

1. Resident #12 was admitted to the facility on 3/3/2020, and diagnoses included a stroke with hemiplegia (paralysis on one side of the body) affecting his right dominant side and aphasia (difficulty speaking).

Resident #12's revised care plan dated 4/1/2022 included a focus for a deficit in performing activities of daily living due to right side weakness. Interventions included assisting Resident #12 with activities of daily living and encouraging Resident #12 to use the call light to call for assistance.

The quarterly Minimum Data Set (MDS) dated 3/31/2023 indicated Resident #12 was moderately impaired cognitively and had limited range of motion to one side of his body.

A dietary note dated 5/17/2023 indicated Resident #12 received a pureed diet with nectar thickened liquids.

On 6/26/2023 at 12:25 p.m., Resident #12's call

F 558

On 06/28/2023 resident #12 and resident #40 call lights were reviewed by the Director of Nursing and were within reach of residents.

0n 6/28/2023 100% of residents call light were reviewed for being accessible and within reach of residents by the Director of Nursing or designee.

On 06/28/2023 100% of staff were re-educated on call light placement and accessibility to residents by the Director of Nursing.

The Director of Nursing or designee will audit 10 residents per week on call light placement and accessibility. The audit will be documented on the call light log to ensure resident accessibility and within reach. The weekly auditing will include Resident #12 and Resident #40.

The call light log will be brought to monthly Quality Assurance and Performance Improvement Committee x3 months by the Director of Nursing or designee for review. Any further action needed will be implemented by the committee as required.

Completion Date 7/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 7	F 558		

light was observed hanging on the connection port in the wall located on the right side of the bed out of the reach of Resident #12. Nurse Aide (NA) #3 was observed delivering and setting up Resident #12's lunch meal tray before exiting his room. Resident #12's call light remained hanging on the connection port in the wall out of the reach of Resident #12.

On 6/26/2023 at 12:59 p.m., Resident #12's call light was observed hanging on the connection port in the wall located on the right side of the bed. NA #2 was observed removing Resident #12's lunch meal tray from the over- the -bed table and exiting the Resident #12's room. When the surveyor requested NA #2 to return to Resident #12's room, NA #2 said she thought Resident #12 could not operate the call light. She explained Resident #12 used his left hand to feed himself using build-up utensils. NA #2 was observed removing the call light that was hanging on the connection port in the wall on the right side of the bed and placing the call light near Resident #12's left hand. NA #2 explained to Resident #12 the call light was used to call for help as needed and when NA #2 instructed Resident #12 to demonstrate using the call by pushing the button at the end of the call light, Resident #12 was able to demonstrate how to use the call light correctly. NA #2 stated the call light was to be left within reach of Resident #12 always when exiting the room.

On 6/28/2023 at 11:01 a.m. in an interview with the Director of Nursing, she stated Resident #12's call light should be within his reach to use to communicate his needs.

On 6/29/2023 at 5:34 p.m. in an interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 8	F 558		

Administrator, she stated call light was to be attached to Resident #12's bed and within Resident #12's reach to call for assistance.

2. Resident #40 was admitted to the facility on 7/14/22.

The annual Minimum Data Set (MDS) dated 5/16/2023 indicated Resident #40 was cognitively intact and was independent for transfer and locomotion on unit.

On 6/26/23 at 12:39 p.m., Resident #40's call light was observed laying on top of a light fixture attached to the wall to the left side of the bed. Resident #40 was observed to be in her wheelchair. She stated she could not reach the call bell and explained she communicated her needs to staff by speaking with them on the hall. She stated the call bell had been on top of the light fixture for a few days but could not recall who had placed it there.

On 6/27/23 at 9:11 a.m the call bell was observed again to be laying on top of the light fixture attached to the wall to the left side of the bed. Resident #40 was observed to be in her wheelchair and stated that if she were unable to get out of bed to use her wheelchair, she would need to utilize the call bell to alert staff of her needs.

On 6/28/2023 at 11:03 a.m. in an interview with the Director of Nursing, she stated Resident #40's call light should be within her reach to use to communicate her needs.

On 6/29/2023 at 5:54 p.m. in an interview with the Administrator, she stated call light was to be

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	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 558	Continued From page 9 within Resident 40's reach to call for assistance.	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to inform residents (Resident #2, #7, #43 and #50) the location of the state inspection results, and failed to provide advocate agency information and failed to display state inspection results accessible to a wheelchair bound resident (Resident #2) for 4 of	F 577	On 6/28/2023, the binder that is clearly marked "Pelican Health of Henderson Survey Results" was relocated to a table in the front entry that is easily accessible to residents and visitors, including those in wheelchairs. The height of the table is approximately 34 inches.	7/25/23

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F 577	Continued From page 10 4 residents in attendance of the Resident Council meeting. The findings included: On 6/28/23 at 11:15 am during a Resident Council meeting, Resident #47, Resident #42, Resident #45, Resident #59 and Resident #41 stated state inspection results were not made available for residents to read and they did not know the location of the state inspection results. They further stated they were unsure of the ombudsman's name and contact information. On 6/28/23 at 11:48 am the state inspection results white binder for the facility was observed on the wall in a file holder, with the base of the clear file holder located approximately fifty-six inches from the floor, beside the business office. There was no label identifying the state inspection results binder observed in the file holder. The binder was placed with the label reading survey results towards the wall. A sign was located across from the business office was located labelled ombudsman information with space for the facility's ombudsman's name and contact information to be filled out. This area on the sign was blank. On 6/28/23 at 11:50 am Resident #2 was observed unable to reach the State Inspection Results binder while sitting in her wheelchair and stated she would be unable to read a label of a binder placed at that height. An interview was conducted with the Administrator on 6/29/23 at 2:30 PM who stated she was unaware the survey inspection results binder should be accessible to residents without	F 577	On 6/28/2023 the advocacy agency information was filled out and updated by the Administrator. The information is located in the front entry, and it is clearly visible to residents and visitors, including those in wheelchairs. On 6/28/2023 Residents #2, #7, #41, #42, #43, #45, #47, and #59 were notified by the Administrator on the location of the state inspection results and advocate agency information. 06/28/2023 the Administrator or designee notified all alert/oriented residents of the location of survey results and advocacy information for the facility. On 6/28/2023 the social worker mailed letters to notify all responsible parties of change in location of survey results and advocacy information for the facility. 06/28/2023 the Administrator was re-educated on ensuring the survey binder was kept up to date by the Regional Vice President of Clinical Operations. On 6/28/2023 the social worker was re-educated by the Administrator on ensuring advocacy information is maintained up to date/accurate, accessible to wheelchair bound residents and residents knew the location of information. Administrator is no longer employed by the facility as of 7/25/2023. The new Administrator was educated by the Chief Clinical Officer on 7/25/2023 on ensuring	

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	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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CAMELLIA GARDENS CENTER FOR NURSING AND REHAB	**280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536**

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F 577	Continued From page 11 assistance. She reported she would have the survey book moved to a lower position so it would be within reach of wheelchair bound residents. The Administrator stated the residents would be educated on the location of the survey inspection results. She reported they had located the ombudsman's information and would ensure it was placed on the signage across from the business office.	F 577	survey results are available to be accessed by residents and visitors and that ombudsman/advocacy agency information is posted where it is available and visible to residents and visitors, including those confined to wheelchairs. The Chief Clinical Officer or designee will audit the location/ accessibility of survey results and advocacy information monthly X3 months, then quarterly. The Activities Director will inform the resident council of the location of the survey binder and ombudsman/advocacy agency information monthly X 3 months, and then quarterly. Audits will be brought to QAPI monthly x 3 months by the Administrator or designee for review. Any further action needed will be implemented by the committee as required. Completion Date 7/25/2023	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		7/25/23

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F 584	Continued From page 12 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews, and staff interviews, the facility failed to keep the room temperature at a comfortable level for 1 of 2 residents sampled (Resident #43). Findings included: Resident # 43 was admitted to the facility on 5/21/2021.	F 584	On 07/3/2023 the maintenance director installed a portable air conditioning unit in the room occupied by Resident #43. The other affected rooms were not occupied. On 7/17/23, an HVAC contractor made partial repairs to the Central HVAC system, reducing the number of affected rooms with only rooms 112, and 114 remaining affected. A ductless mini-split	

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F 584	Continued From page 13 The quarterly Minimum Data Set (MDS) assessment dated 5/4/2023 indicated Resident #43 was cognitively intact and required assistance with all activities of daily living except eating. The weekly temperature log for the main building indicated Resident #43's room temperature was not checked on 6/1/2023, 6/7/2023 and 6/16/2023. On 6/16/2023, the Accuweather website recorded temperatures for Henderson, North Carolina (NC) as the high was 87 degrees Fahrenheit and low was 62 degrees Fahrenheit. Maintenance Director notes indicated on 6/16/2023 he was made aware of an air conditioner problem for the hall with rooms 107 to 114 by nursing station #1, and a Heating, Ventilation and Air Conditioner (HVAC) service company was contacted. A receipt dated 6/16/2023 revealed the facility purchased three portable air conditioners. A review of Resident #43's electronic medical record revealed on 6/16/2023 Resident #43 was moved from room 111 to room 107 in the facility. On 6/20/2023, the Accuweather website recorded temperatures for Henderson, NC as the high was 76 degrees Fahrenheit and low was 64 degrees Fahrenheit. On 6/20/2023 at 8:30 a.m., the Maintenance Director's temperature checks for Resident #43's room indicated the room temperature was 74.8 degrees Fahrenheit.	F 584	system was ordered to provide supplementary heating and cooling for those rooms and for the end of the hall. On 07/24/2023 the maintenance director completed a 100% audit of rooms affected by HVAC ventilation. No concerns were identified, all residents to include resident #43 were comfortable with current room temperatures, and temperatures were within limits of regulatory compliance. On 7/24/2023 the Director of Nursing or designee re-educate all staff on notification of AC/ HVAC failure or malfunction to the maintenance director. On 7/25/23, Resident #43 was moved to an unaffected part of the facility. Affected resident rooms will remain unoccupied until the new system arrives and is installed by the HVAC contractor. Prior to re-occupying the affected rooms, the administrator will confirm the issue is resolved and that the temperatures are expected to remain within compliance levels going forward. In the interim, a portable A/C unit will be utilized to ensure temperature compliance in the hallway. The Maintenance Director or designee will audit 100% of rooms affected by HVAC 107 thru 111 2x per day for one month followed by once per day thereafter. The audit log will be brought to monthly QAPI x 3 months by the maintenance director. Any further action needed will be	

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F 584	Continued From page 14	F 584		

Maintenance Director notes indicated the air conditioner was serviced and repaired by the HVAC service company on 6/20/2023.

A review of Resident #43's electronic medical record revealed on 6/20/2023, Resident #43 was moved back to room 111.

The Maintenance Director's temperature checks for Resident #43's room:
- 6/21/2023 at 9:00 a.m. 75 degrees Fahrenheit.
- 6/22/2023 at 8:25 a.m. 75.3 degrees Fahrenheit.
- 6/23/2023 at 9:50 a.m. 75.6 degrees Fahrenheit.

There were no temperatures logged for Resident #43's room for the mid-afternoon or afternoon hours on each day.

On 6/23/2023, the weekly temperature log for the main building indicated Resident #43's room temperature was 75 degrees Fahrenheit,

The Accuweather website recorded temperatures for Henderson, NC on:
- 6/24/2023, the high was 82 degrees Fahrenheit and low was 64 degrees Fahrenheit
- 6/25/2023, the high was 86 degrees Fahrenheit and low was 66 degrees Fahrenheit.

The Maintenance Director's temperature checks for Resident #43's room:
- 6/26/2023 at 9:00 a.m. 74.6 degrees Fahrenheit.
- 6/27/2023 at 9:40 a.m.72 degrees Fahrenheit.
- 6/28/2023 at 9:15 a.m. 73.5 degrees

implemented by the committee as required.

Completion date 7/25/23

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	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 584	Continued From page 15	F 584		

Fahrenheit.
- 6/29/2023 at 8:45 a.m. 74.5 degrees Fahrenheit.

There were no temperatures logged for Resident #43's room for the mid-afternoon or afternoon hours on each day.

On 6/26/2023 at 11:00 a.m. while walking down the hallway for rooms 107-114, the air in the hall was noticeably warmer half-way down the hall after passing room 109 and room 110. There was a fan observed in the hallway outside room 110. In the empty room 112 across from Resident #43's room, a portable air conditioner unit was observed in the mid of the room. The air blowing from the portable air conditioner was cool to touch and a temperature reading of 79 degrees Fahrenheit was observed on the portable air conditioner unit.

On 6/26/2023 at 3:41 p.m., Maintenance Director checked the hall temperature. The reading at the end of the hall temperature was observed at 91.9 degrees Fahrenheit and 92.3 degrees Fahrenheit. Resident #43's room temperature check was 75.5 degrees Fahrenheit along the side of the outside wall in the room. There was a circulating tall standing fan observed between the door and Resident #42 bed, and a portable air conditioner positioned in the doorway of the bathroom facing toward the foot of the bed.

On 6/26/2023 at 3:48 p.m. the hall thermostat control for rooms 107 to 114 was observed set at 74 degrees Fahrenheit, and the temperature reading was observed at 82 degrees Fahrenheit.

In an interview with the Maintenance Director on 6/26/2023 at 3:37p.m., he stated the hallway and

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F 584	Continued From page 16	F 584		

rooms 111-114 at the back of the hall were noticeably warm the morning of 6/26/2023. He stated he had placed two portable air conditioner units in room 112 and placed one portable air conditioner in Resident #43's room the morning of 6/26/2023. He explained the air conditioner was working, but something was wrong with it, and he had called a Heating, Ventilation and Air Conditioner (HVAC) service company again on 6/26/2023.

In an interview with Resident #43 on 6/26/2023 at 3:41p.m., she stated about three weeks ago when the air conditioner started messing up, the facility provided her a box fan to keep her room temperature more comfortable. She said during the weekend of 6/24/2023 and 6/25/2023 her room temperature became uncomfortable, and the nursing staff provided her plenty of fluids and attempted to locate another fan for her room but couldn't find one. In a follow- up interview on 6/29/2023 at 6:42 a.m., she explained the warmer room temperature at first was bearable because she was anemic and was given a fan in her room. She said the daily outside temperatures were getting warmer, but there were still some days with cool outside temperatures, and it wasn't that hot in her room. She stated it was hotter in the hallway because when staff entered her room, she could feel the heat come into the room. She stated the Maintenance Director was checking the room temperatures and told him the room temperature was bearable. On 6/16/2023, she said her room became really hot and although she did not want to move from room 111, the facility explained outside temperatures were to increase and needed someone to come to the facility to check the air conditioner. She said she was moved to room 107 on 6/16/2023, and

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F 584	Continued From page 17 Maintenance Director checked room temperatures daily reporting unable to moved back into room 111. She stated she returned to her room 111 on 6/20/2023. She explained she was the only resident moved off the hall to return to their room on 6/20/2023 and noticed a new resident was admitted to room 107 on 6/20/2023 after she was returned to her room. She said room 111 was still warmer than usual after returning on 6/20/2023, but the cool outside temperature in the evenings and a fan in her room kept the room temperature more comfortable. She explained when the door was closed for personal care, the room would get even hotter. She stated over the weekend of 6/24/2023 and 6/25/2023, outside temperatures were not cooling down in the evenings as much and the room temperature became hotter to the point, she was wiping sweat. She said on the weekend of 6/24/2023 and 6/25/2023. she did not see the Maintenance Director, and nursing staff kept ice and water for her to drink. She stated on 6/26/2023 when the Maintenance Director asked her if it was hot in her room, she told him hotter than melted butter. She stated the Maintenance Director informed her someone had unplugged the portable air conditioners on the hall over the weekend of 6/24/2023 and 6/25/2023 and brought in a portable air conditioner to her room on the morning of 6/26/2023 and therefore, felt there was unnecessary heat in her room over the weekend of 6/24/2023 and 6/25/2023. She said after the portable air conditioner was placed in her room on 6/26/2023, her room temperature had cooled down to a comfortable room temperature for her. In a follow up interview with the Maintenance Director on 6/29/2023 at 1:13 p.m., he stated the	F 584		

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F 584	Continued From page 18	F 584		

HVAC service company informed him the air conditioner unit was working with limited airflow and needed supplemental airflow. He explained the facility received estimates on installation of ductless air conditioner units that were approved on 6/27/2023, and he was informed on 6/29/2023 to order. He explained on 6/16/2023 when the air conditioner unit was not working to keep rooms 111 to 114 cool, the residents were moved to other rooms in the facility. He stated Resident #43 wanted to go back to her room 111. He stated he tried to keep room temperatures less than 74 degrees Fahrenheit and on 6/16/2023 room temperatures for rooms 111-114 ranged from 76-77 degrees Fahrenheit. He explained he checked room temperatures throughout the day but didn't record all the room temperatures obtained throughout the day. He stated he was on call all the time, and no one called and reported Resident #43's room being too hot on 6/24/2023 and 6/25/2023. On 6/26/2023, Resident #43 was warmer than usual and placed a portable air conditioner in her room.

In an interview with Nurse #3 on 6/29/2023 at 2:03 p.m., he stated Resident #43's room was very hot the weekend of 6/24/2023 and 6/25/2023 and did not recall the resident complaining about the room being too hot. He stated she would let you know if something was wrong.

In an interview with Nurse Aide (NA) #4 and NA #5 on 6/29/2023 at 2:52 p.m., NA #5 stated Resident #43 complained of her room being hot on 6/24/2023 and 6/25/2023. They stated rooms 111-114 at the end of the hall have been hot for the last two months, and Administration and the Maintenance Director were aware of the situation.

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F 584	Continued From page 19 In a phone interview with the operator of a local HVAC service company on 6/29/2023 at 1:38 p.m., he stated he checked the facility's air conditioner on 6/20/2023. He explained the air conditioner unit needed to be upgraded, and the facility's one unit was performing all that it could. He stated the ducts under the ground were full of water and retaining water in the duct work created a humidity issue that was more uncomfortable than heat. He said he was told by the maintenance director there were four rooms that were usually warmer than rest of the facility, but he did not check the temperature of the rooms inside of the facility. In an interview with the Administrator on 6/29/2023 at 5:15 p.m., she stated sometime before 6/15/2023 the air conditioner unit went down, and there was a noticeable increase in the temperature in rooms 109 to 114. She explained the Maintenance Director was monitoring room temperatures, fans were placed in resident rooms as needed, and residents including Resident #43 were moved off the hall. The Administrator stated Resident #43 was moved back to room 111 on 6/20/2023 after the air conditioner was serviced, and the room temperature was measuring 68-72 degrees Fahrenheit. She also stated Resident #43 was correct in saying a new resident was admitted to room 107 after Resident #43 returned to room 111 and stated Resident #43 wanted to move back to room 111. She explained the facility purchased and placed portable air conditioners on the hall to combat the increasing room temperatures rooms for rooms 109-114. She stated during the weekend of 6/24/2023 and 6/25/2026, the portable air conditioners somehow had been turned off causing an increased in Resident #43's room temperature during that	F 584		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 20 time. She stated the Maintenance Director was not informed of the increased room temperature in Resident #43's room on the weekend of 6/24/2023 and 6/25/2023. She said due to lack of communication, Resident #43's increased room temperature was not addressed on 6/24/2023 and 6/25/2023.	F 584		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to accurately assess the use of restraints (Resident #28) and cognitive and mood patterns (Resident #45, #41, #18, #30, #47, #53) for 7 of 25 residents whose Minimum Data Set (MDS) were reviewed. Findings included: 1. Resident #28 was admitted to the facility on 4/19/2021. A review of nursing documentation dated 2/2/2023 to 5/2/2023 did not indicate the use of a trunk restraint or any type of restraint on Resident #28. There was no physician order for the use of a restraint for Resident #28. The quarterly Minimum Data Set (MDS) assessment dated 5/3/2023 indicated Resident #28 was cognitively intact and exhibited verbal	F 641	On 06/28/2023 resident #28 MDS assessment was modified by the MDS Coordinator to properly reflect her restraint-free status. On 7/24/2023 100% review of restraint assessments were reviewed for accuracy for MDSs completed in the last 30 days by the MDS Nurse. Any inaccuracies identified were modified and resubmitted by the MDS Nurse. On 7/24/23 the MDS Nurse completed cognitive and mood assessments for #45, #41, #18, #30, and #47. #53 was not assessed as he was no longer in the facility. On 7/24/2023 the MDS Nurse completed a 100% audit of Brief Interview Mental Services (BIMS) Assessment and PHQ9 for completion for all current residents. Any residents that did not have a BIMs or	7/25/23

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F 641	Continued From page 21 behaviors toward others and other behavioral symptoms not directed toward others. The MDS also indicated the use of a trunk restraint in the seven-day look back period for the MDS. In an interview with Resident #28 on 6/26/2023, she stated the staff had not been applied any type of restraints to her while at the facility. In an interview with Nurse Aide #1 on 6/28/2023 at 3:30 p.m., she stated Resident #28 was confused at times and verbally aggressive toward other. She said Resident #28 had not been physically aggressive and restraints had not been applied to Resident #28 for her aggressive behaviors. In an interview with Nurse #2 on 6/28/2023 at 3:35 p.m., she stated restraints were not used in the facility and had not been applied to Resident #28. She explained Resident #28 sometimes exhibited outburst of loud verbal aggression to staff and other residents and was not physically aggressive toward others. In an interview with the Director of Nursing (DON) on 6/28/2023 at 11:01 a.m., she explained restraints were not used in the facility, and she was not aware of a time a restraint was used on Resident #28. She further stated the facility did not have any type of restraints in the facility to use on residents and that was an error in the coding Resident #28 for restraints. In an interview with MDS Nurse #1 on 6/28/2023 at 3:30 p.m., she stated in answering the questions for restraints on the quarterly MDS, she missed clicked trunk restraint by mistake. She explained Resident #28 should had been coded	F 641	PHQ9 assessment completed were assessed by the MDS Nurse. On 06/29/2023 the Corporate MDS Coordinator re-educated the social worker, director of nursing, staff development and MDS Coordinator on completion of Brief Interview Mental Services Assessment for all residents upon admission, quarterly and with changes. 06/29/2023 the Corporate MDS Coordinator re-educated the MDS Coordinator on accuracy of restraint assessments and completion of mood assessments. The Director of Nursing (DON) will audit MDSs for accurately assessing restraints and for completing BIMs assessments and mood assessments in the 7 day look back period for all assessments weekly for one month and then monthly for two more months. The audit results will be brought to QAPI monthly x 3 months by the DON. Any further action needed will be implemented by the committee as required. Completion Date 7/25/23	

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F 641	Continued From page 22 "no" for trunk restraint. In an interview on 6/28/2023 at 10:43 a.m. with Nurse #1, the registered nurse who reviewed and signed the quarterly MDS dated 5/3/2023 was complete, stated she didn't review the MDS information word for word and did not see when reviewing that MDS Nurse #1 had coded in error the use of a trunk restraint on Resident #28's MDS. In an interview on 6/29/2023 at 5:12 p.m. with the Administrator, she stated the MDS assessment should reflect an accurate picture of Resident #28's condition, and the facility was not conducting audits to review accuracy of MDS assessments. 2. Resident #45 was admitted to the facility on 8/3/21. Resident #45's quarterly Minimum Data Set (MDS) assessment dated 5/25/23 revealed he was not assessed for cognition and mood. The assessment indicated an interview for assessment should have been attempted. An assessment was conducted based on staff observations which assessed him as cognitively intact with no mood symptoms. An interview was conducted with MDS Nurse #1 on 6/29/23 at 3:00 PM who stated she completed an interview with residents during their assessment period but was unable to input it into the computerized tool. She stated it was her	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 23	F 641		

understanding that if the interview was not placed in the tool before the Assessment Reference Date (ARD) it could not be utilized as part of the assessment.

During an interview with the Administrator on 6/29/23 at 4:00 PM she stated MDS assessments should be completed with the information gathered during the assessment process.

3. Resident #41 was admitted to the facility on 4/7/21 with diagnoses that included dementia.

Resident #41's annual MDS assessment dated 4/14/23 revealed he was not assessed for cognition and mood. The assessment indicated an interview for the assessment should have been attempted. An assessment was conducted based on staff observations which assessed him as having a moderate cognitive impairment with no mood symptoms.

An interview was conducted with MDS Nurse #1 on 6/29/23 at 3:00 PM who stated she completed an interview with residents during their assessment period but was unable to input it into the computerized tool. She stated it was her understanding that if the interview was not placed in the tool before the Assessment Reference Date (ARD) it could not be utilized as part of the assessment.

During an interview with the Administrator on 6/29/23 at 4:00 PM she stated MDS assessments should be completed with the information gathered during the assessment process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 641	Continued From page 24	F 641		

4. Resident #18 was admitted to the facility on 5/9/23 with diagnoses that included major depressive disorder.

Resident #18's admission MDS assessment dated 5/15/23 revealed he was not assessed for cognition and mood. The assessment indicated an interview for the assessment should have been attempted. An assessment was conducted based on staff observations which assessed him as cognitively intact with no mood symptoms.

An interview was conducted with MDS Nurse #1 on 6/29/23 at 3:00 PM who stated she completed an interview with residents during their assessment period but was unable to input it into the computerized tool. She stated it was her understanding that if the interview was not placed in the tool before the Assessment Reference Date (ARD) it could not be utilized as part of the assessment.

During an interview with the Administrator on 6/29/23 at 4:00 PM she stated MDS assessments should be completed with the information gathered during the assessment process.

5. Resident #30 was admitted to the facility on 1/9/23 with diagnoses that included dementia.

Resident #30's quarterly MDS assessment dated 4/18/23 revealed he was not assessed for cognition and mood. The assessment indicated an interview for the assessment should have been attempted. An assessment was conducted based on staff observations which assessed him as cognitively intact with no mood symptoms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 25	F 641		

An interview was conducted with MDS Nurse #1 on 6/29/23 at 3:00 PM who stated she completed an interview with residents during their assessment period but was unable to input it into the computerized tool. She stated it was her understanding that if the interview was not placed in the tool before the Assessment Reference Date (ARD) it could not be utilized as part of the assessment.

During an interview with the Administrator on 6/29/23 at 4:00 PM she stated MDS assessments should be completed with the information gathered during the assessment process.

6. Resident #47 was admitted to the facility on 8/20/21 with diagnoses that included post-traumatic stress disorder.

Resident #47's quarterly MDS assessment dated 5/15/23 revealed he was not assessed for cognition and mood. The assessment indicated an interview for the assessment should have been attempted. An assessment was conducted based on staff observations which assessed him as cognitively intact with no mood symptoms.

An interview was conducted with MDS Nurse #1 on 6/29/23 at 3:00 PM who stated she completed an interview with residents during their assessment period but was unable to input it into the computerized tool. She stated it was her understanding that if the interview was not placed in the tool before the Assessment Reference Date (ARD) it could not be utilized as part of the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 641	Continued From page 26	F 641		
	During an interview with the Administrator on 6/29/23 at 4:00 PM she stated MDS assessments should be completed with the information gathered during the assessment process.			
	7. Resident #53 was admitted to the facility 3/3/23.			
	Resident #53's quarterly MDS assessment dated 5/12/23 revealed he was not assessed for cognition and mood. The assessment indicated an interview for the assessment should have been attempted. An assessment was conducted based on staff observations which assessed him as cognitively intact with no mood symptoms.			
	An interview was conducted with MDS Nurse #1 on 6/29/23 at 3:00 PM who stated she completed an interview with residents during their assessment period but was unable to input it into the computerized tool. She stated it was her understanding that if the interview was not placed in the tool before the Assessment Reference Date (ARD) it could not be utilized as part of the assessment.			
	During an interview with the Administrator on 6/29/23 at 4:00 PM she stated MDS assessments should be completed with the information gathered during the assessment process.			
F 644 SS=D	Coordination of PASARR and Assessments	F 644		7/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 644	Continued From page 27	F 644		

CFR(s): 483.20(e)(1)(2)

§483.20(e) Coordination.
A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:

§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to refer a resident with a newly evidence diagnosis of serious mental illness for a level II Pre-Admission Screening Resident Review (PASRR) for 1 of 3 residents reviewed for PASSR (Resident #47).

The findings included:

Resident #47 was admitted to the facility on 8/20/21 with diagnoses that included post-traumatic stress disorder.

Review of a psychiatric progress note dated 1/18/23 revealed Resident #47 had been diagnosed with schizoaffective disorder.

On 07/24/2023 the social worker submitted a request for a level II PASSR for resident #47.

On 07/24/2023 the administrator completed a 100% audit of residents PASSR□s in the building. Any resident identified to have an inappropriate PASSR level was re-submitted to NC Must by the social worker.

On 07/24/2023 the social worker was re-educated by the Administrator on submitting PASSR level II for any resident that indicates a suspicion, or produces evidence, of serious mental illness (SMI),

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	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 644	Continued From page 28 Review of Resident #47's record revealed no screening for a level II PASSR. Resident #47's quarterly MDS assessment dated 5/15/23 revealed he was assessed as cognitively intact with no mood symptoms. During the 7-day lookback period he had behavioral symptoms not directed towards others 1-3 days. His diagnoses on the assessment included post-traumatic disorder and schizoaffective disorder. Resident #47 received antipsychotic, antidepressant, and anti-anxiety medications 7 of the 7 days of the lookback period. Review of Resident #47's care plan dated 5/29/23 revealed he was care planned for schizoaffective disorder and post-traumatic disorder. Interventions included mental health consults as needed and compliance with medications. An interview with Social Worker #1 on 6/29/23 at 10:42 AM was conducted. She stated had been employed with the facility since May 2023 and was unsure who requested screenings for level II PASSRs. An interview was conducted with the Administrator on 6/29/23 at 12:15 PM and she stated currently there was no one in the building who had the access to request level II PASSR screenings and once the access was received a level II PASSR screening would be requested for Resident #47.	F 644	intellectual or developmental disabilities (I/DD) or a related condition (RC) as defined by State and federal guidelines. The Administrator or designee will audit residents□ medical diagnosis for new admission, quarterly, and with significant change assessments for medical diagnosis that will trigger a level II PASSR submission weekly for 4 weeks and then monthly for two months. The audit will be brought to QAPI monthly x 3 months by the Administrator or Designee. Any further action needed will be implemented by the committee as required. Completion Date 7/25/2023	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		7/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 695	Continued From page 29 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to place signage indicating the use of oxygen and failed to administer supplemental oxygen as prescribed for 4 of 4 residents reviewed for oxygen (Resident #19, #53, #214 and #25.) Findings included: 1. Resident #19 was admitted to the facility on 10/21/2022 with diagnosis that included shortness of breath. The annual Minimum Data Set (MDS) assessment dated 5/11/23 indicated Resident #19 was cognitively intact and used supplemental oxygen. Physician orders dated 6/13/2023 included oxygen at 2 liters continuously by nasal cannula for shortness of breath. On 6/27/2023 at 9:24 a.m. Resident #19 was observed wearing oxygen via nasal cannula. There was no warning signage observed to communicate oxygen in use outside the room on the door or door frame. In an interview with the Director of Nursing on	F 695	On 06/28/2023 the Director of Nursing posted warning signage outside resident #19, #53, #214 and #25 doors. On 06/28/2023 the Director of Nursing or designee completed a 100% audit of all current residents receiving oxygen for the warning signage on the residents door frames. Any resident requiring a warning sign was provided one. On 06/28/2023 all nursing staff were re-educated by the Director of Nursing or designee on posting warning signs on the door frame of residents with oxygen in place. The Director of Nursing or Designee will complete a weekly audit of all residents receiving oxygen for warning signage posting outside of residents door for 4 weeks and then monthly for 2 more months. . The audit results will be brought to the monthly QAPI x 3 months by the Director of Nursing or Designee. Any further action needed will be implemented by the committee as required.	

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	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 695	Continued From page 30	F 695		

6/28/2023 at 10:58a.m., she stated a red magnetic warning sign should had been placed outside the residents' door or door frame to communicate oxygen was in use in the room. She explained the Maintenance Director had the oxygen warnings signs and was responsible for placing on the outside of resident rooms. She stated if nursing was responsible, she would make sure magnetic "oxygen in use" warning signs were placed on the residents' doors.

In an interview with the Maintenance Director on 6/28/2023 at 11:26a.m., he stated he was not responsible for applying oxygen warning signs outside residents' rooms. He explained he had not seen the facility use magnetic "oxygen in use" warning signs in the facility and he would have to order some magnetic "oxygen in use" warning signs. He stated the nurse that admitted the residents would have been responsible to apply the "oxygen in use" warning sign on the door.

2. Resident #53 was admitted to the facility on 3/3/23 with diagnoses that included chronic respiratory failure.

The admission Minimum Data Set (MDS) assessment dated 3/10/23 indicated Resident #53 was cognitively intact and used supplemental oxygen.

Physician orders dated 3/6/23 included oxygen at 3 liters continuously by nasal cannula for chronic respiratory failure.

On 6/26/23 at 1:59 p.m., Resident #53 was observed to be receiving supplemental oxygen

Completion date 7/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 31	F 695		

via nasal cannula. There was no warning signage observed to communicate oxygen in use outside the room on the door or door frame.

In an interview with the Director of Nursing on 6/28/2023 at 10:58a.m., she stated a red magnetic warning sign should had been placed outside the residents' door or door frame to communicate oxygen was in use in the room. She explained the Maintenance Director had the oxygen warnings signs and was responsible for placing on the outside of resident rooms. She stated if nursing was responsible, she would make sure magnetic "oxygen in use" warning signs were placed on the residents' doors.

In an interview with the Maintenance Director on 6/28/2023 at 11:26a.m., he stated he was not responsible for applying oxygen warning signs outside residents' rooms. He explained he had not seen the facility use magnetic "oxygen in use" warning signs in the facility and he would have to order some magnetic "oxygen in use" warning signs. He stated the nurse that admitted the residents would have been responsible to apply the "oxygen in use" warning sign on the door.

3. Resident #214 was admitted to the facility on 6/15/23 with diagnoses that included heart failure.

Physician orders dated 6/15/2023 included oxygen at 2 liters continuously by nasal cannula for heart failure.

The admission Minimum Data Set (MDS) had not been completed for Resident #214.

On 6/26/2023 at 2:54p.m. Resident #214 was observed wearing oxygen via nasal cannula at 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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F 695	Continued From page 32	F 695		

liters per minute. There was no warning signage observed to communicate oxygen in use outside the room on the door or on the door frame.

On 6/29/23 at 3:38p.m. an interview and observation was completed with Nurse #3 who was providing care for Resident #214. Nurse #3 observed Resident #214 to be receiving supplemental oxygen at 3 liters per minute. Nurse #3 confirmed that Resident #214's oxygen order was for 2 liters per minute and explained the flow rate should match Resident #214's order. Nurse #3 stated that it was the responsibility of the nurses to check the flow rate each shift and that he had not checked it that day.

In an interview with the Director of Nursing on 6/28/2023 at 10:58a.m., she stated a red magnetic warning sign should had been placed outside the residents' door or door frame to communicate oxygen was in use in the room. She explained the Maintenance Director had the oxygen warnings signs and was responsible for placing on the outside of resident rooms. She stated if nursing was responsible, she would make sure magnetic "oxygen in use" warning signs were placed on the residents' doors.

In an interview with the Maintenance Director on 6/28/2023 at 11:26a.m., he stated he was not responsible for applying oxygen warning signs outside residents' rooms. He explained he had not seen the facility use magnetic "oxygen in use" warning signs in the facility and he would have to order some magnetic "oxygen in use" warning signs. He stated the nurse that admitted the residents would have been responsible to apply the "oxygen in use" warning sign on the door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING ______ B. WING ______	C 06/29/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 33	F 695		

4. Resident #25 was admitted to the facility on 9/19/2017. Diagnoses included chronic obstructive pulmonary disease.

Resident #25's care plan revised 9/09/2023 included a focus for oxygen therapy due to ineffective gas exchange. Interventions included changing oxygen tubing and nebulizer supplies weekly and providing extension tubing and portable oxygen for ambulation. Use of warning signs for use of oxygen was not included as an intervention.

Physician orders dated 9/28/2021 included oxygen at 2 liters continuously by nasal cannula to keep oxygen saturation above 90%.

The quarter Minimum Data Set (MDS) assessment dated 5/10/23 indicated Resident #25 was cognitively intact and used oxygen.

On 6/26/2023 at 12:13p.m. Resident was observed wearing oxygen via nasal cannula at 2 liters per minute. There was no warning signage observed to communicate oxygen in use outside the room on the door or on the door frame.

In an interview with the Director of Nursing on 6/28/2023 at 10:58a.m., she stated a red magnetic warning sign should had been placed outside Resident #25's door or door frame to communicate oxygen was in use in the room. She explained the Maintenance Director had the oxygen warnings signs and was responsible for placing on the outside of Resident #25's room. She stated if nursing was responsible, she would make sure magnetic "oxygen in use" warning signs were placed on the resident's doors.

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F 695	Continued From page 34 In an interview with the Maintenance Director on 6/28/2023 at 11:26a.m., he stated he was not responsible for applying oxygen warning signs outside residents' rooms. He explained he had not seen the facility use of magnetic "oxygen in use" warning signs in the facility and he would have to order some magnetic "oxygen in use" warning signs. He stated the nurse that admitted Resident #25 would have been responsible to apply the "oxygen in use" warning sign on the door.	F 695		