STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/19/24 through 02/24/24. Additional information was obtained offsite on 02/27/24. Therefore, the exit date was changed to 02/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 2ORC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/19/24 through 02/22/24. Additional information was obtained offsite on 02/27/24. Therefore, the exit date was changed to 02/27/24. Event ID# 2ORC11. The following intakes were investigated: NC00201452, NC00207096, NC00207877, NC00210470, NC00211453, NC00212400, NC00212749, and NC00212866. 1 of the 14 complaint allegations resulted in deficiency.	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 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).	F 578		3/20/24

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

Electronically Signed | 03/20/2024

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F 578	Continued From page 1 (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 record review, resident, staff, Physician Assistant and Medical Director interviews, the facility failed to clarify and update medical records to reflect the desired advanced directives for 2 of 3 residents reviewed for code status (Resident #30 and Resident #75). The findings included: 1. Resident #30 was re-admitted to the facility on 1/3/24.	F 578	The facility will continue to clarify and update medical records to reflect the desired advanced directives. Resident #□s 30 and 75 were interviewed on 2.20.24 regarding their right to formulate an advance directive and results were documented in the electronic medical record by the Unit Managers. No negative outcome was identified relating to these observations.	

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F 578	Continued From page 2 The quarterly Minimum Data Set (MDS) assessment dated 11/28/23 indicated Resident #30 was cognitively intact. Review of Resident #30's Care Plan, which was last reviewed on 1/6/24, revealed no information regarding the resident advanced directives. Review of the facility advanced directive/ code book located at the nurses' station revealed a physician signed Do Not Resuscitate (DNR) form on goldenrod colored paper dated 12/20/23 and an Emergency Response Directive-NC (North Carolina) form dated 12/20/23 signed by both the physician and Resident #30 that indicated to do not attempt resuscitation if Resident #30 had no pulse and was not breathing. Further review of Resident #30's electronic medical record revealed a physician order dated 12/20/23 and signed by the Medical Director on 12/25/23 for No CPR/DNR (cardiopulmonary resuscitation/ do not resuscitate). Review of Resident #30's Admission Nursing Assessment dated 1/3/24 revealed Resident #30 did want CPR. This was indicated by "yes" being marked on the Admission Nursing Assessment for the question titled "Does the resident want CPR." Additional review of Resident #30's electronic medical record revealed an updated Emergency Response Directive-NC form had been completed by Resident #30 and scanned into the electronic medical record on 1/3/24. The updated form was signed by Resident #30 on 1/3/24 and indicated her desire for resuscitation if her heart or breathing stopped. The form was signed by the	F 578	Current residents have the potential to be affected. Current resident medical records were audited by the DON and Unit Managers from 2.20.24 □ 2.21.24 to ensure that each resident had been provided the right to formulate an advance directive and wishes documented in the electronic medical record. No negative outcome was identified relating to this audit. All licensed nurses, Social Workers and Medical Records clerk were in-serviced by the ADON on the facility policy for ensuring that each resident is provided the right to formulate an advance directive and wishes documented in the electronic medical record as of 2.21.24. Any newly hired licensed nurses, Social Workers and Medical Records clerks hired after2.21.24 will receive the same education prior beginning their first shift on the floor. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/Unit Managers/or designee beginning on 2.22.24. The DON/Unit Managers/or designee will randomly audit 10 resident charts weekly x 4 weeks then 5 resident charts weekly x 4 weeks then 5 resident charts biweekly x 4 weeks to ensure advance directives are ordered and documented according to resident wishes. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Audit results will be reported to the Administrator weekly for the next 3	

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F 578	Continued From page 3 facility Medical Director on 1/14/24. An interview was conducted with Resident #30 on 2/20/24 at 3:12 PM. Resident #30 stated she remembered changing her code status when she was readmitted to the facility after her hospitalization. She said she wanted CPR and resuscitation if her heart stopped, or she stopped breathing. Resident #30 stated, "I know they say it is horrible and can be painful for someone my age, but it is how I feel right now." An interview was performed on 2/20/24 at 3:28 PM with Nurse #3. She stated resident code status was located in the electronic medical record and in the advanced directive/ code book located at the nurse's station. She explained the advanced directive/ code book contained the resident emergency response directive-NC form, original DNR (Do Not Resuscitate) form, and original MOST (Medical Orders for Scope of Treatment) form. She stated she was unsure who updated code status orders in the electronic medical record or advance directive forms if a resident's code status changed. Nurse #3 reviewed Resident #30's electronic medical record revealing No CPR/DNR as her code status. Nurse #3 checked the advance directive/ code book at the nurses' station further revealing a physician signed DNR form and resident emergency response directive- NC form both dated 12/20/23 for Resident #30. Nurse #3 explained if Resident #30 had an acute episode, was not breathing, or did not have a heart beat she would not perform CPR. An interview was performed on 2/20/24 at 5:05 PM with the Unit Manager (UM) #2. UM #2 stated education on advance directives was included in	F 578	months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random electronic medical record audits and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 3.20.24	

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F 578	Continued From page 4	F 578		

the admission packet for the resident and family. She stated code status was discussed with the resident or resident representative (RR) on admission, and the resident or RR chose their desired code status. She stated a resident's code status should always be addressed on admission in case the resident or RR changed their mind. UM #2 explained an emergency response directive- NC form is signed by the physician and the resident or RR indicating their desired code status. She explained the physician completed advance directive DNR/MOST forms when needed. She stated after advance directive forms were completed, the forms were scanned into the electronic medical record by Medical Records. She explained a copy of the advance directive forms were made for the advance directive/ code book until the original forms returned from medical records. UM #2 stated when the original advanced directive forms returned from medical records the copied forms were removed from the advanced directive/ code book and replaced with the original form. She verbalized the process was the same if a resident changed their mind and wanted to change their code status. She said all old advance directive paperwork should be removed from the advanced directive/ code book and replaced with new forms if a resident changed their code status. UM #2 reviewed Resident #30's electronic medical record and stated Resident #30 has a No CPR/ DNR order. UM #2 reviewed the most recent emergency response directive- NC form scanned into Resident #30 electronic medical record on 1/3/24 revealing Resident #30's desire for resuscitation/ full code. UM #2 was unable to locate any additional updated advanced directive forms for Resident #30 since 1/3/24. She stated she was not sure why Resident #30's code status had not

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F 578	Continued From page 5	F 578		

been changed in her electronic health record or in the advanced directive/ code book. UM #2 stated if Resident #30 had an acute episode, was not breathing, or did not have a heartbeat she would not have received CPR and the outcome for Resident #30 would likely be death.

An interview was conducted on 2/21/24 at 5:48 PM with the Medical Director. The Medical Director stated he did not specifically remember completing Resident #30's updated emergency response directive- NC form but he completed and signed a lot of paperwork. He stated if Resident #30 wanted to change her status to be resuscitated and he signed the form, then Resident #30 should be a full code. He stated when Resident #30 returned from the hospital the facility should have updated her code status. He explained if Resident #30 wanted to change her code status to be resuscitated her medical record and orders should have been updated.

An interview was performed on 2/22/24 at 3:45 PM with the Director of Nursing (DON). The DON explained the inaccuracy of Resident #30's advance directives was complicated by multiple hospitalizations. She stated Resident #30's electronic health record, orders, and the advance directive/ code book should have been updated to reflect Resident #30's desired code status. The DON explained the facility's process for updating advance directives. She stated nurses had the physician complete/ sign the residents advance directives, then a copy was made for the advance directive/ code book, and the original form was given to Medical Records. She said Medical Records scanned the original advance directive forms into the resident's electronic health record. Then they replaced the copied forms in the

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F 578	Continued From page 6	F 578		

advance directive/ code book with the original advance directive forms. She stated the advance directive/ code books at the nurses' station are updated by the nurses and nurse managers. She explained the code status order in the electronic health record was updated by the Nurse Manager when there is a change. The DON stated conversations were held with residents or RR about updating advanced directives on admission, quarterly during care plans, and when there was a change in a resident's condition. She voiced the facility needed to perform audits on all advance directives to ensure they are correct.

An interview with the Administrator was performed on 2/22/24 at 4:55 PM. The Administrator stated Resident #30's advance directives should have been changed in the electronic medical record, orders, and in the advance directive/ code book to reflect her desire for full code. She explained a resident's advance directive order in the electronic medical record and in the advance directive/ code book should be exactly the same and reflect the resident's wishes.

2. Resident #75 was admitted to the facility on 8/17/23.

A review of Resident #75's electronic medical record indicated a physician's order dated 8/17/23 for no cardiopulmonary resuscitation (CPR)/do not resuscitate (DNR). A copy of the "Emergency Response Directive" dated 8/17/23 was in Resident #75's electronic medical record and it indicated that if his heart or his breathing stopped, he understood that no CPR would be initiated. This form was signed by Resident #75 and the Nurse Practitioner on 8/17/23.

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F 578	Continued From page 7	F 578		

A review of the advance directive binder at the nurses' station revealed a paper copy of Resident #75's emergency response directive dated 8/17/23 that indicated no CPR. In addition, a Medical Orders for Scope of Treatment (MOST) form dated 11/15/23 was also in the binder and it indicated to attempt resuscitation with limited additional interventions. The MOST form was signed by Resident #75 and the Physician Assistant (PA) on 11/15/23.

A progress note in Resident #75's medical record dated 11/15/23 by the PA indicated Resident #75 agreed to discuss his advance directive. Resident #75 agreed to CPR but do not intubate. Resident #75 agreed to limited additional interventions which included hospitalization, antibiotics if indicated, intravenous fluids for defined trial period, and no feeding tube. Resident #75 was alert and oriented x 3 (to time, place and person).

The most recent quarterly Minimum Data Set assessment dated 12/19/23 indicated Resident #75's cognitive patterns were not assessed.

An interview with Unit Manager (UM) #1 on 2/20/24 at 4:53 PM revealed she did not know that Resident #75 had two conflicting advance directives in the advance directive binder. UM #1 stated the PA should have notified her or the nurses so they could have changed Resident #75's advance directive order in his chart and she could have forwarded the most recent MOST form to Medical Records to get it scanned into his electronic medical record.

An interview with the Physician Assistant (PA) on

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F 578	Continued From page 8 2/21/24 at 4:28 PM revealed he did not specifically remember the conversation with Resident #75 on 11/15/23 but he did express to him that he wanted CPR. The PA stated after Resident #75 signed and after he signed the MOST form on 11/15/23, he went ahead and filed it in the advance directive book which was at the nurses' station. The PA stated he thought he was being helpful, and he was not aware of the facility's systems at that time. The PA shared that he didn't know the most current advance directive had to be scanned into the electronic medical record. An interview with the Director of Nursing (DON) on 2/20/24 at 5:20 PM revealed she and UM #1 went back and talked to Resident #75 and he told them that he wanted to be DNR. The DON stated the PA did not notify them of the change in Resident #75's advance directive on 11/15/23. The DON further stated they recently identified an issue with the correct advance directives not being scanned into the medical record and had talked to their providers, but they didn't go back and check the previous advance directives for all residents. The DON shared that this was a concern because if a resident had conflicting advance directive, they would follow the one that was most recently signed.	F 578		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 602		3/11/24

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F 602	Continued From page 9 any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Detective interviews, the facility failed to protect a resident's right to be free from misappropriation of property when a staff member (Nurse Aide #1) used Resident #283's personal credit card to make multiple purchases without the resident's consent. The deficient practice was for 1 of 3 residents reviewed for misappropriation of resident property (Resident #283). The findings included: A review of the facility's Abuse Prohibition Policy dated 9/22/22 indicated each guest/resident shall be free from abuse, neglect, mistreatment, exploitation and misappropriation of property. It defined misappropriation of guest/resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of guest's/resident's belongings or money without the guest's/resident's consent. Resident #283 was admitted to the facility on 8/28/23 and was cognitively intact. He was at the facility for short-term rehabilitation and discharged home on 9/10/23. The Facility Reportable Incident (FRI) was reviewed. On 9/6/23 staff notified the Director of Nursing (DON) and Administrator that Resident #283 was missing his credit card. The unit manager spoke to Resident #283 and asked when the last time he saw the card or remembered using it. Resident #283 stated on 9/4/23 he went to the vending machine in the	F 602	The facility will continue to ensure that residents are protected from misappropriation of property. Resident #283 no longer resides at the facility. Current residents have the potential to be affected. Current alert and oriented residents were interviewed between 3.5.24 – 3.8.24 by the interdisciplinary team to determine if they had concerns regarding misappropriation of property in the facility. There were no negative outcomes identified resulting from these interviews. 100% of facility staff were in-serviced by the ADON on the Abuse Policy and Procedure. The education emphasized a resident's right to be free from abuse, including misappropriation of property. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. This education was completed on 3.8.24. Newly hired employees after 3.8.24 will receive mandatory in person education by the ADON during general orientation prior to the start of their first shift. The education will emphasize a resident's right to be free from abuse, including misappropriation of property. Definitions and types of abuse, prevention of abuse,	

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F 602	Continued From page 10 evening to get a few candy bars. Resident #283 stated it was dark in the dining room so he used the flashlight on his phone to follow the instructions to use his credit card. Resident #283 stated that somewhere between getting the candy bars on 9/4/23 and 9/6/23 was when the card went missing. On 9/6/23 the Resident noticed that there were charges on his credit card for that were not his. Resident #283 froze his account by calling the credit card company. Resident #283 reported the charges to the unit manager. Resident #283 showed the unit manager that there were several food locations all over Asheville area and a spa where his credit card was used. On 9/6/23 at 8:30 PM the local Police Department was notified. An interview with the Director of Nursing (DON) on 2/22/24 at 3:31 PM revealed that the facility had found online that Resident #283's credit card had been used. Resident #283 could not remember where he had lost the credit card. As soon as the facility was made aware of the missing credit card the police were called. Both DON and the Administrator called all the businesses the card was used to try and find who had the stolen card. The DON stated that the detective was able to find a video with a matching time stamp of the missing card being used. The police showed the DON the still picture of the person and the DON recognized the person to be an employee who worked in the facility as Nurse Aide (NA) #1. The DON stated that NA #1 had only worked at their facility a few times. The police told the DON that they were going to make an arrest. The DON stated they had not heard anything more about the case. The DON stated that NA #1 was terminated right after they identified him on the video.	F 602	identification of abuse, and protecting residents from abuse will be reviewed as well as reporting examples from the state operations manual. A QA monitoring tool will be utilized to ensure ongoing compliance beginning on 3.11.24. The Social Worker/designee will interview 5 residents and/or responsible parties 5x/week x 2 weeks, then 3x/week x 2 weeks, then weekly x 4 weeks, then bi-weekly x 4 weeks to ensure that there are no concerns with misappropriation of resident property. Any concerns identified through facility interviews will be immediately reported to the Administrator for follow-up and additional education or corrective action provided when indicated. Interview results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random interviews and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance 3.11.24	

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F 602	Continued From page 11 An interview with the Administrator on 2/22/24 at 4:33 PM revealed the facility wasn't sure if Resident #283 had left his credit card in the vending machine or dropped it. Resident #283 checked his credit card statements and noticed charges on his card that were not his. The local police department was called, and the Administrator started calling the businesses that the credit card had been used at. One of the local businesses stated they did have a video of a person using the card but could only release the video to the police. The police officer showed the Administrator the picture of the person and recognized him as NA #1. The police officer stated they were going to charge him. The Administrator stated the facility never got a police report regarding if he was charged or not so they did not report to the nurse aide registry. On 2/27/24 at 8:30 AM received by email a copy of a police report. The name of the suspect on the police report was the same name as NA #1 which was given by the facility. No information was in the report regarding an arrest. On 2/27/24 at 9:45 AM a phone interview with the assigned Detective revealed that NA #1 was arrested for fraud.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		3/25/24

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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F 609	Continued From page 12 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit an initial and 5-day investigation report to the State Survey Agency after confirming Nurse Aide #1 had used a resident's credit card for personal purchases for 1 of 3 residents reviewed for misappropriation of resident property (Resident #283). The findings included: Resident #283 was admitted to the facility on 8/28/23 and was cognitively intact. He was at the facility for short-term rehabilitation and discharged home on 9/10/23.	F 609	The facility will continue to ensure that residents are protected from misappropriation of property and submit an initial and 5-day investigation report to the State Survey Agency. Resident #283 no longer resides at the facility. Current residents have the potential to be affected. Current alert and oriented residents were interviewed between 3.5.24 □ 3.8.24 by the interdisciplinary team to determine if they had concerns regarding misappropriation of property in	

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F 609	Continued From page 13 The Facility Reportable Incident (FRI) was reviewed. On 9/6/23 staff notified the Director of Nursing (DON) and Administrator that Resident #283 was missing his credit card. Resident #283 stated that somewhere between getting the candy bars on 9/4/23 and 9/6/23 was when the card went missing. On 9/6/23 the Resident noticed that there were charges on his credit card for that were not his. Resident #283 froze his account by calling the credit card company. Resident #283 reported the charges to the unit manager. Resident #283 showed the unit manager that there were several food locations all over Asheville area and a spa where his credit card was used. On 9/6/23 at 8:30 PM the local Police Department was notified. An interview with the Director of Nursing (DON) on 2/22/24 at 3:31 PM revealed that the facility had found online that Resident #283's credit card had been used. Resident #283 could not remember where he had lost the credit card. As soon as the facility was made aware of the missing credit card the police were called. Both DON and the Administrator called all the businesses where the card was used to try and find who had the stolen card. The DON stated that the detective was able to find a video with a matching time stamp of the missing card being used. The police showed the DON the still picture of the person and the DON recognized the person to be an employee who worked in the facility as Nurse Aide (NA) #1. The police told the DON that they were going to make an arrest. The DON stated that NA #1 had only worked at their facility a few times. The DON stated they had not heard anything more about the case. The DON stated that NA #1 was terminated right after they	F 609	the facility. There were no negative outcomes identified resulting from these interviews. 100% of facility staff were in-serviced by the ADON on the Abuse Policy and Procedure. The education emphasized a resident□s right to be free from abuse, including misappropriation of property. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse were reviewed as well as reporting examples from the state operations manual. This education was completed on 3.8.24. Newly hired employees after 3.8.24 will receive mandatory in person education by the ADON during general orientation prior to the start of their first shift. The education will emphasize a resident□s right to be free from abuse, including misappropriation of property. Definitions and types of abuse, prevention of abuse, identification of abuse, and protecting residents from abuse will be reviewed as well as reporting examples from the state operations manual. A QA monitoring tool will be utilized to ensure ongoing compliance beginning on 3.11.24. The Social Worker/designee will interview 5 residents and/or responsible parties 5x/week x 2 weeks, then 3x/week x 2 weeks, then weekly x 4 weeks, then bi-weekly x 4 weeks to ensure that there are no concerns with misappropriation of resident property. Any concerns identified through facility interviews will be immediately reported to the Administrator for follow-up and additional education or corrective action provided when indicated.	

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F 609	Continued From page 14 identified him on the video. An interview with the Administrator on 2/22/24 at 4:33 PM revealed the facility wasn't sure if Resident #283 had left his credit card in the vending machine or dropped it. Resident #283 checked his credit card statements and noticed charges on his card that were not his. The local police department was called, and the Administrator started calling the businesses that the credit card had been used at. One of the local businesses stated they did have a video of a person using the card but could only release the video to the police. The police officer showed the Administrator the picture of the person and recognized him as NA #1. The police officer stated they were going to charge him. The Administrator stated the facility never got a police report regarding if he was charged or not so they did not report to the nurse aide registry. The Administrator also stated she did not know what she needed to do because she had already completed her 5-day investigation report on 9/8/23 which is when the investigation was complete. On 9/11/23 the Administrator submitted the report to the State Survey Agency wherein she unsubstantiated the misappropriation of resident property because at that time, she did not know what had happened to Resident #283's credit card. The Administrator added that without having the official police report, she could not substantiate the allegation against NA #1 even though they had identified him on the video. On 2/27/24 at 8:30 AM received by email a copy of a police report. The name of the suspect on the police report was the same name as NA #1 which was given by the facility. No information was in the report regarding an arrest.	F 609	Interview results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. An addendum to the original initial and 5-day reportable were filed with the state including the CNA's name and police report showing his arrest for the incident. The facility also notified the Health Care Personnel Registry of his misconduct and sent the information. Continued compliance will be monitored through random interviews and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance 3.25.24	

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F 609	Continued From page 15 On 2/27/24 at 9:45 AM a phone interview with the assigned Detective revealed that NA #1 was arrested for fraud.	F 609		
F 641 SS=B	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 and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of cognitive patterns, mood, and the Pre-Admission Screening and Resident Review (PASRR) level for 4 of 6 residents (Resident #35, Resident #75, Resident #53 and Resident #30) whose MDS were reviewed. The findings included: 1. Resident #35 was admitted to the facility on 10/29/20. The quarterly Minimum Data Set (MDS) assessment dated 1/5/24 for Resident #35 indicated the questions in the sections for cognitive patterns, and mood were not assessed. A joint interview with the Social Services Worker (SSW) and the Social Services Director (SSD) was conducted on 2/22/24 at 11:27 AM. The SSW stated that they were responsible for completing the sections for cognitive patterns and mood in the MDS assessments. The SSW shared that she only worked part-time and at the	F 641	The facility will continue to code MDS assessments in the areas of cognitive patterns, mood, and the Pre-Admission Screening and Resident Review (PASRR) level. Residents # 35, 75, and 53 had BIMs and PHQ2-9 assessments completed on 2.22.24 by the social worker. PASRR were also reviewed and updated for resident's #53, 30. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. All current residents were reviewed on 2.22.24-3.18.24 by the MDS Coordinator to ensure that assessments in the areas of cognitive patterns and mood had been completed and accurately reflect each resident's PASRR status. No negative outcomes were identified relating to these observations. The MDS Coordinator, MDS Assistant, and Social Workers were in serviced by the DON and Regional Clinical Consultant	3/21/24

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F 641	Continued From page 16 time of Resident #35's quarterly MDS assessment, the previous SSD completed it while working from home. She stated that she was not sure why the cognitive patterns and mood were not assessed for Resident #35, but she knew that they were not supposed to check "not assessed." The SSW stated that they were supposed to attempt to complete the sections for cognitive patterns and mood. The SSD who started working at the facility on 1/22/24 stated that the previous SSD was probably the manager on duty that day and that the SSW was probably not at the facility on the day when Resident #35's MDS was supposed to be completed. An interview with the MDS Coordinator on 2/22/24 at 11:55 AM revealed the SSD did not complete Resident #35's cognitive and mood assessment within the 7-day window so she indicated that they were not assessed. The MDS Coordinator stated these two assessments were time-specific and must be completed and signed by the assessment reference date (ARD). An interview with the Director of Nursing on 2/22/24 at 3:40 PM revealed she did not know why Resident #35's MDS was not completed accurately but it was probably hard for the part-time SSW to manage all the MDS assessments that were due to be completed. An interview with the Administrator on 2/22/24 at 4:48 PM revealed there were some misses in the MDS assessments during the transition between the previous SSD and the new SSD. The Administrator stated that Resident #35's cognitive patterns and mood were not assessed because they were not completed within the ARD, but they shouldn't be doing that.	F 641	on 3.5.24 on completing MDS assessments in the areas of cognitive patterns, mood, and the Pre-Admission Screening and Resident Review (PASRR) level. Any newly hired MDS Coordinators/Assistants and Social Workers hired after 3.5.24 will receive the same education by the Clinical Resource Specialist prior to beginning their first shift on the floor. A QA monitoring tool will be utilized to ensure ongoing compliance by the MDS Coordinator/designee beginning on 3.6.24. The MDS Coordinator/designee will randomly audit 5 resident MDS's weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 4 weeks to ensure that MDS assessments in the areas of cognitive patterns, mood, and the Pre-Admission Screening and Resident Review (PASRR) level. Variances will be corrected at the time of audit and additional education, or corrective action provided when indicated. Audit results will be reported to the Administrator monthly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be	

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F 641	Continued From page 17 2. Resident #75 was admitted to the facility on 8/17/23. The quarterly Minimum Data Set (MDS) assessment dated 12/19/23 for Resident #75 indicated the questions in the sections for cognitive patterns, and mood were not assessed. A joint interview with the Social Services Worker (SSW) and the Social Services Director (SSD) was conducted on 2/22/24 at 11:27 AM. The SSW stated that they were responsible for completing the sections for cognitive patterns and mood in the MDS assessments. The SSW shared that she only worked part-time and at the time of Resident #75's quarterly MDS assessment, the previous SSD completed it while working from home. She stated that she was not sure why the cognitive patterns and mood were not assessed for Resident #75, but she knew that they were not supposed to check "not assessed." The SSW stated that they were supposed to attempt to complete the sections for cognitive patterns and mood. The SSD who started working at the facility on 1/22/24 stated that the previous SSD was probably the manager on duty that day and that the SSW was probably not at the facility on the day when Resident #75's MDS was supposed to be completed. An interview with the MDS Coordinator on 2/22/24 at 11:55 AM revealed the SSD did not complete Resident #75's cognitive and mood assessment within the 7-day window so she indicated that they were not assessed. The MDS Coordinator stated these two assessments were time-specific and must be completed and signed by the assessment reference date (ARD).	F 641	provided for any issues identified. Date of compliance: 3.21.24	

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F 641	Continued From page 18	F 641		

An interview with the Director of Nursing on 2/22/24 at 3:40 PM revealed she did not know why Resident #75's MDS was not completed accurately but it was probably hard for the part-time SSW to manage all the MDS assessments that were due to be completed.

An interview with the Administrator on 2/22/24 at 4:48 PM revealed there were some misses in the MDS assessments during the transition between the previous SSD and the new SSD. The Administrator stated that Resident #75's cognitive patterns and mood were not assessed because they were not completed within the ARD, but they shouldn't be doing that.

3. Resident #53 was admitted to the facility on 11/24/20.

The PASRR Level II Determination Notification dated 5/1/23 indicated Resident #53 had a PASRR Level II with no end date and no limitation unless there was a change in condition. It further indicated that no specialized services were required, and that the nursing facility placement was appropriate.

The significant change in status Minimum Data Set (MDS) assessment dated 5/15/23 indicated Resident #53 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.

A joint interview with the Social Services Worker (SSW) and the Social Services Director (SSD) was conducted on 2/22/24 at 11:27 AM. The SSW stated that they were responsible for

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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F 641	Continued From page 19	F 641		

completing the section for PASRR level in the comprehensive MDS assessments. The SSW shared that they missed the PASRR level II on Resident #53's significant change MDS but she was not sure how they missed it.

An interview with the MDS Coordinator on 2/22/24 at 11:55 AM revealed the SSD and SSW were responsible for completing the PASRR level on the comprehensive assessments and she was supposed to check them for accuracy. The MDS Coordinator stated that she should have caught the error in Resident #53's MDS assessment and it should have indicated that she had a PASRR level II.

An interview with the Administrator on 2/22/24 at 4:48 PM revealed Resident #53's PASRR level II should have been indicated in her significant change MDS.

4. Resident #30 was initially admitted to the facility on 4/17/23. She was re-admitted on 5/31/23.

The PASRR Level II Determination Notification dated 5/26/23 indicated Resident #30 had a Halted - PASRR Level II Authorization with no end date and no restrictions. It further indicated that Resident #30 did not meet the federal definition for intellectual and developmental disability and would not be subject to further evaluations under the PASRR process at this time. This implied either that there was no evidence of intellectual and developmental disability or there was a primary diagnosis of dementia. The halted reason was that the individual screened did not meet criteria for a mental illness.

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 20 The admission Minimum Data Set (MDS) assessment dated 6/7/23 indicated Resident #30 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. A joint interview with the Social Services Worker (SSW) and the Social Services Director (SSD) was conducted on 2/22/24 at 11:27 AM. The SSW stated that they were responsible for completing the section for PASRR level in the comprehensive MDS assessments. The SSW shared that they missed the PASRR level II on Resident #30's admission MDS but she was not sure how they missed it. An interview was conducted with the MDS Coordinator and the Regional MDS Nurse on 2/22/24 at 11:55 AM. The MDS Coordinator stated the SSD and SSW were responsible for completing the PASRR level on the comprehensive assessments and she was supposed to check them for accuracy. The Regional MDS Nurse stated that because Resident #30 had a halted PASRR, it was not a level II and that Resident #30's admission MDS was completed correctly. An interview with the Administrator on 2/22/24 at 4:48 PM revealed Resident #30's PASRR level II should have been indicated in her admission MDS and that a halted PASRR was a level II.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review	F 644		3/21/24

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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F 644	Continued From page 21 (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 record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for residents with new mental health diagnoses for 1 of 3 residents (Resident #55) reviewed for PASRR. The findings include: Review of Resident #55's medical record revealed the resident had a PASRR level I completed prior to admission dated 07/21/21 and was admitted to the facility on 10/14/22. The resident was diagnosed with anxiety disorder on 08/11/23 and major depressive disorder and vascular dementia, moderate, with psychotic disturbance on 10/24/23. No PASRR level II had been completed per Resident #55 medical records. During an interview on 02/22/24 at 11:27AM with	F 644	The facility will continue to ensure a Preadmission Screening and Resident Review (PASRR) is completed for residents with new mental health diagnoses. Residents #55 had updated PASRR screening applications completed as of 3.18.24 by the Social Worker. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. All current residents were reviewed on 2.22.24 by the MDS Coordinator and Social Worker to ensure that current PASRR's on file were accurate. No negative outcomes were identified relating to these observations. The MDS Coordinator, MDS Assistant,	

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F 644	Continued From page 22 the part-time and full-time social worker (SW) revealed the part-time SW had worked at the facility since April 2023 3 days a week but had never been made responsible for applying for PASRR or trained on when or how to apply for them. The full-time SW stated she had only worked at the facility for 1 month and was currently receiving training on PASRR to include when to apply for one, which PASRR required reviews, and how to send in requested information for PASRR. Both SWs revealed they were not aware of any residents in the facility requiring a level II PASRR but believed if a resident had a mental health diagnosis on admission, a significant change in their behavior, or was given a new diagnosis a PASRR should be completed. During an interview on 02/22/24 at 4:37 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #55 added diagnosis of anxiety disorder, major depressive disorder, and vascular dementia, moderate, with psychotic disturbance a PASRR level II should have been completed.	F 644	and Social Worker were in serviced by the DON and Corporate Clinical Consultant on 3.5.24 on the facility policy for PASRR management. Any newly hired MDS Coordinators/Assistants and Social Workers hired after 3.5.24 will receive the same education by the Corporate MDS liaison prior to beginning their first shift on the floor. A QA monitoring tool will be utilized to ensure ongoing compliance by the Social Worker/designee beginning on 3.7.24. The Social Worker/designee will randomly audit 5 resident medical records weekly x 8 weeks, then bi-weekly x 4 weeks to ensure that medical records accurately reflect the resident's PASRR status. Variances will be corrected at the time of audit and additional education or corrective action provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 3.21.24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 656	Continued From page 23	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		3/20/24

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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F 656	Continued From page 24 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with resident, staff and the Nurse Practitioner, the facility failed to follow a resident's care plan and allowed a resident who was assessed as unsafe to self-administer medications for 1 of 1 resident observed with medication at the bedside (Residents #22). The findings included: Resident #22 was admitted to the facility on 12/11/15 with diagnoses that included end-stage renal disease. The quarterly Minimum Data Set assessment dated 12/13/23 indicated Resident #22 was moderately cognitively impaired, and was dependent on staff assistance with most activities of daily living. A review of Resident #22's medical record indicated no physician's order for self-administration of medications. Resident #22's care plan last revised on 1/6/24 indicated Resident #22 had history of not consuming all medications provided to him during his medication administration and at times pills	F 656	The facility will follow the resident□s care plan and not allow a resident who was assessed as unsafe to self-administer medications. Resident #22 no longer resides at the facility. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. The DON and ADON immediately conducted a facility walk through on 2.20.24 and interviewed all licensed nurses and medication aides working at the time to ensure that no other residents had medications left at the bedside that was not care planned and deemed safe to be able to self-administer medications. No negative outcomes were identified relating to these observations. 100% of licensed nurses and medication aides were in-serviced by the ADON on the facility policy for self-administration of medication that includes modification of the careplan on 2.20.24. All newly hired licensed nurses and medication aides hired after 2.20.24 will receive the same education by the ADON prior to beginning	

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 656	Continued From page 25 were found in his jacket or shorts pockets, in his bedside table, or in the trash can. Due to decreased dexterity, increased weakness at times, and inability to steadily hold the medication cup, medications were often spilled when/if he attempted to administer the medications to himself from a medication cup. Resident #22 was at risk for increased medication non-compliance. Interventions included to administer medications by spoon whole as he preferred, and reinforce with Resident #22 as needed that medications could not be left at bedside for him to take. A review of Resident #22's Medication Administration Record for February 2024 indicated an active physician's order for Sevelamer Carbonate 800 milligrams - give 2 tablets by mouth four times a day for dialysis. (Sevelamer is used to lower the amount of phosphorus in the blood of patients receiving kidney dialysis.) There was also an order which started on 1/7/24 for medications to be administered by nurse with spoon due to loss of dexterity causing medications to spill from cup and history of hiding pills. An observation of Resident #22 on 2/20/24 at 1:02 PM during the lunch meal in his room revealed a medication cup containing two large white pills on his bedside table right next to his meal tray. An interview with Resident #22 during this observation revealed he had forgotten what those two pills were for but that he was supposed to take them with meals. Resident #22 stated that the nurse left it at his bedside because he was still eating his lunch. An interview with Medication Aide (MA) #1 on	F 656	their first shift on the floor. The DON or designee will utilize a QA monitoring tool to ensure ongoing compliance beginning on 2.21.24. The Don or designee will randomly inspect 5 resident rooms 5 times per week x 4 weeks, then 5 resident rooms 3 times per week x 4 weeks, then 5 resident rooms weekly x 4 weeks to ensure that no resident□s without applicable care plans, evaluations and orders have medications left at the bedside. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 3.20.24	

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 656	Continued From page 26	F 656		

2/20/24 at 1:19 PM revealed he handed the medication cup to Resident #22 but didn't watch him take his pills because the Nurse Practitioner was in the room at that time. MA #1 stated he usually handed the medication cup to Resident #22 and watched him take his medications. MA #1 further stated that he had not used a spoon to administer Resident #22's medications to him and he was not sure if Resident #22 had been assessed to self-administer his medications.

An interview with Nurse #1 on 2/20/24 at 2:46 PM revealed he was assigned to Resident #22 and oversaw MA #1. Nurse #1 stated that Resident #22 could take his medications whole, but he was not sure if he needed some apple sauce to help him swallow his bigger pills. Nurse #1 stated he was not sure why there was an order to spoon Resident #22's medications to his mouth when administering medications to him because he would usually hand him the medication cup and he could take his medications by himself. Nurse #1 stated that he knew they were supposed to observe Resident #22 take his medications and not leave them at the bedside, and that no resident had been assessed that they could take medications on their own.

A phone interview with the Nurse Practitioner (NP) on 2/21/24 at 6:05 PM revealed when she visited Resident #22 on 2/20/24 he did not have a lunch tray on his bedside table, and she did not see a medication cup at the bedside. The NP stated that if she saw the nursing staff leave Resident #22's pills at the bedside, she would have said something to them because this could be an issue. The NP stated that leaving medications at the bedside was not acceptable because they would not know whether Resident

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F 656	Continued From page 27 #22 would take his medications or not. An interview with Unit Manager (UM) #1 on 2/22/24 at 12:13 PM revealed Resident #22 had an order to use a spoon to administer his medications because he had a history of dropping and spilling his pills whenever he was handed the medication cup. UM #1 stated that sometimes Resident #22 refused to take his medications or often requested to leave his medications at the bedside to take later but they should not have left his medications at the bedside. An interview with the Director of Nursing (DON) on 2/22/24 at 3:40 PM revealed Resident #22 would not be a candidate to safely administer medications to himself. The DON stated Resident #22 probably persuaded MA #1 to leave his medications at the bedside, but he should have followed the facility policy which was not to leave medications at the bedside.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		3/6/24

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 692	Continued From page 28 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident, staff, and the Medical Director, the facility failed to provide a nutritional supplement ordered by the physician for 2 of 4 residents (Resident #19 and Resident #12) reviewed for nutrition. The findings included: 1. Resident #19 was admitted to the facility on 9/13/16 with diagnoses that included diabetes, chronic kidney disease, anemia (condition in which the blood doesn't have enough healthy red blood cells and hemoglobin), vitamin D deficiency and dysphagia (difficulty swallowing). The significant change in status Minimum Data Set (MDS) assessment dated 1/14/24 indicated Resident #19 was cognitively intact, required partial/moderate assistance with eating and had the following signs and symptoms of possible swallowing disorder: holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, and complaints of pain when swallowing. The MDS further indicated that Resident #19's height was 63 inches and weight was 146 pounds during the assessment period, and she had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6	F 692	The facility will continue to provide a nutritional supplement ordered by the physician. Resident #19 and #12 will continue to receive nutritional supplements per physician's orders. No negative outcome was identified relating to this observation. Current residents with orders for nutritional supplements have the potential to be affected. Current residents with orders for nutritional supplements were reviewed by the Unit Managers on 2.21.24 to ensure that they are receiving supplements per physician's orders. No negative outcome was identified relating to these observations. All dietary staff and licensed nurses were inserviced by the Registered Dietician and/or ADON as of 3.5.24 on ensuring that nutritional supplements are provided and documented per physician's orders. Any newly hired dietary staff, licensed nurses, and C N A's hired after 3.5.24 will receive the same education by the ADON prior to beginning their first shift on the floor. A QA monitoring tool will be utilized to	

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F 692	Continued From page 29 months and was not on a physician-prescribed weight loss regimen. A review of Resident #19's medical record indicated a physician's order dated 1/17/24 for a frozen nutritional supplement for weight loss two times a day with lunch and dinner. Resident #19's care plan last revised on 2/6/24 indicated Resident #19 was at nutritional and/or dehydration risk related to impaired mobility, required assistance with meal set-up, history of weight loss, poor intake, vitamin D deficiency, and increased swallowing difficulty. Continued decline was expected related to medical condition. Interventions included to provide diet as ordered: regular diet, mechanical soft texture, thin consistency liquids, and (frozen nutritional supplement) with lunch and dinner, and to provide supplements as ordered for weight loss. Resident #19's Medication Administration Record (MAR) for February 2024 indicated documentation through initials that the (frozen nutritional supplement) was given two times a day for weight loss at 12:00 PM and at 5:00 PM on 2/19/24 and 2/20/24. An observation on 2/19/24 at 1:22 PM of Resident #19 during the lunch meal revealed her lunch tray on a bedside table in front of her while Resident #19 was sitting up in bed. She was observed talking on her phone and was not eating her food. There was no frozen nutritional supplement on her lunch tray. A second observation of Resident #19 on 2/20/24 at 1:25 PM revealed her lunch tray on her bedside table in front of her. A review of the meal	F 692	ensure ongoing compliance by the Dietary Manager beginning on 3.6.24. The Dietary Manager will randomly observe meal trays of 5 residents 5x/week for 2 weeks, then 5 residents 3x/week x 2 weeks, then 5 residents weekly x 4 weeks, then 5 residents biweekly x 4 weeks to ensure that nutritional supplements are provided and documented per physician's orders. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 3.6.24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 692	Continued From page 30	F 692		

ticket on the tray revealed a frozen nutritional supplement was supposed to be served with lunch and dinner. The food was untouched and there was no frozen nutritional supplement on the lunch tray. Resident #19 reported that she felt sick to her stomach, and was nauseated. Resident #19 declined to answer any questions about her supplements.

A third observation of Resident #19 on 2/21/24 at 12:45 PM revealed no frozen nutritional supplement on her lunch tray. An interview with Resident #19 during this observation revealed that she was trying to figure out what the frozen nutritional supplement was that was listed on her meal ticket because she didn't get any at lunch or dinner this week. Resident #19 reported that she felt better today and would try to eat some.

An interview with Nurse #1 on 2/21/24 at 1:04 PM revealed Resident #19's frozen nutritional supplement was supposed to come with her meal tray from the kitchen but was not sure why it had not been there. Nurse #1 stated that he had documented on Resident #19's MAR on 2/19/24 at 5:00 PM and 2/20/24 at 12:00 PM without visualizing if the frozen nutritional supplement was on the tray. Nurse #1 further stated he just assumed that it was on Resident #19's meal tray. Nurse #1 added that he was going to check with the kitchen if there were some available.

A phone interview with Nurse #2 on 2/22/24 at 10:38 AM revealed Nurse #1 told him that the frozen nutritional supplement came from the kitchen and to go ahead and sign for it on 2/20/24 at 5:00 PM without checking if it came on her supper tray. Nurse #2 stated he wasn't sure if Resident #19 received the frozen nutritional

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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F 692	Continued From page 31	F 692		

supplement on her supper tray on 2/20/24 and he did not go back to see how much was consumed. Nurse #2 also shared that Nurse #1 was orienting him on 2/20/24 and he was also assigned to Resident #19, but he did not see her at lunch time because he was busy administering medications.

An interview with the Dietary Manager (DM) on 2/21/24 at 3:03 PM revealed there was miscommunication with his dietary staff when they failed to put the frozen nutritional supplement on Resident #19's tray. The DM stated a dietary aide told him that they didn't know that the shipment had come in and that they thought the frozen nutritional supplement was just regular ice cream which was why they didn't put it on Resident #19's tray. The DM further stated that they have had issues in the past with obtaining the frozen nutritional supplement and he could understand why there was confusion. He shared that they received the shipment on 2/20/24 right before lunch time but his staff assumed there were none available. The DM also stated he usually placed an order for the frozen nutritional supplement at least once a week or every two weeks whenever they were down to half a case.

An interview with the Registered Dietician (RD) on 2/21/24 at 3:17 PM revealed Resident #19 has had a significant weight loss due to several acute and chronic medical issues including nausea and dementia. The RD stated that Resident #19's weight loss might be unavoidable due to these superimposed medical issues. The RD also stated that she had recommended for Resident #19 to receive a frozen nutritional supplement with lunch and dinner, and this was included in the meal ticket for staff to make sure it was placed on her meal tray. The RD stated that she

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

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F 692	Continued From page 32	F 692		

knew the nurses were supposed to make sure that she received it, but this was not realistic and practical for the nurses to be following up on the supplement. The RD also shared that she came to the building once a week and she looked at trays on the hall, and she didn't think the supplements were omitted routinely. The RD further stated that she heard there was a communication issue in the kitchen and if they were not available, they could have called her, and she would have recommended something else.

A phone interview with the Medical Director (MD) on 2/21/24 at 5:51 PM revealed Resident #19 should have received the frozen nutritional supplement as ordered and this order was in place to help with her weight loss. The MD stated that he did not think Resident #19's not receiving the frozen nutritional supplement would contribute to further weight loss.

An interview with the Director of Nursing (DON) on 2/22/24 at 3:40 PM revealed the nurses typically should look at Resident #19's meal tray to make sure she was receiving her frozen nutritional supplement. The staff member who serves the meal tray should do the last check ideally, but they usually did not always look for complete accuracy. The DON stated the tray check was focused more on making sure the right food consistency was served, adaptive equipment was on the tray and food preferences were honored. The DON added that they could do better with making sure the ordered supplements were served according to the meal ticket.

An interview with the Administrator on 2/22/24 at

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 692	Continued From page 33	F 692		

4:48 PM revealed the meal trays should be checked by the DM but everybody was responsible for making sure the ordered supplements were placed on the meal tray. The Administrator stated that the dietary aides should put them on the tray and then the nursing staff who deliver the tray to the residents should make the last check to make sure the residents receive the ordered supplements.

2. Resident #12 was admitted to the facility on 4/7/17 with diagnoses including Parkinson disease, Huntington disease, dysphagia and dementia with mood disturbance.

The Minimum Data Set (MDS) quarterly assessment dated 2/9/24 for Resident #12 revealed that she was cognitively intact. She would lose liquids and solids from her mouth when eating. She coughed and choked during meals. She would complain of difficulty or pain when swallowing. She had lost 5% or more weight in the last month. She was on a mechanically altered diet and had no dental issues.

A physician's order dated 2/14/23 for Resident #12 was on a pureed texture, regular consistency diet, frozen nutritional supplement at lunch, 2 handled cup and divided plate.

Observations of Resident #12's lunch tray was observed on 2/19/24 at 1:07 PM, 2/20/24 at 12:54 PM and 2/21/24 at 12:49 PM and no frozen nutritional supplement was on the tray. The frozen nutritional supplement was listed on the tray ticket.

The Medication Administration Record (MAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF GREENTREE RIDGE	70 SWEETEN CREEK ROAD ASHEVILLE, NC 28803

(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 692	Continued From page 34	F 692		

showed that on 2/21/24 at 12:00 PM Nurse #5 signed that the frozen nutritional supplement was on the lunch tray.

During an interview on 2/21/24 at 2:20 PM with Nurse #5 it was revealed that the nurse did sign off that Resident #12 received the frozen nutritional supplement on her lunch tray. The nurse did not check to ensure the Resident #12 received the frozen nutritional supplement and stated the Resident #12 usually got it and thought she did on 2/21/24.

During an interview on 2/21/24 at 3:03 PM with the Dietary Manager revealed that he was aware of the frozen nutritional supplement not being on the trays. The Dietary Manager stated that the staff did not know there was any frozen nutritional supplement in the freezer. The staff thought they only had ice cream. He stated the kitchen received a delivery on 2/20/24 at 11 AM, the products did not get offloaded till after lunch. The Dietary Manager stated he places an order for product every 1 or 2 weeks and tries to always keep 2 cases of the frozen nutritional supplement.

During an interview on 2/21/24 at 3:17 PM with the Registered Dietician revealed that she did not think that the missing frozen nutritional supplement is a routine missed item. The registered Dietician stated that Resident #12 is on palliative care and is heading towards failure to thrive, so her weight loss was expected.

During an interview on 2/21/24 at 3:40 PM with the Medical Director revealed that the Resident #12 should have been getting the frozen nutritional supplement as ordered. The Medical

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F 692	Continued From page 35 Director did not feel the missing item would make a difference to her weight loss, but if an item is ordered it should be available. During an interview on 2/22/24 at 3:40 PM with the Director of Nursing (DON) revealed that the nurse aide that is setting up the tray for Resident #12 should be checking the ticket on the tray to ensure it was correct. During an interview on 2/22/24 at 4:49 PM with the Administrator revealed that she had been made aware of Resident #12 not receiving the frozen nutritional supplement. The Administrator said that there were several staff who should be checking the ticket. The first being the kitchen staff and Dietary Manager. Then the nurse aide should also be checking the ticket to make sure it was correct.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Medical Director interviews, the facility failed to obtain orders for the use of supplemental oxygen for 1 of 1 resident reviewed for oxygen (Resident # 30).	F 695	The facility will continue to ensure all resident's have active orders for supplemental oxygen and ensure it is administered per physician order.	3/1/24

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F 695	Continued From page 36 The findings included: Resident #30 was re-admitted to the facility on 1/3/24 after hospitalization with diagnoses which included acute and chronic respiratory failure (the respiratory system cannot adequately provide oxygen to the body), pneumonia (an infection of the lungs), and congestive heart failure (a condition in which the heart does not pump blood as efficiently as it should). Review of Resident # 30 quarterly Minimum Data Set dated 11/28/23 indicated she was cognitively intact and received oxygen while she was at the facility. Review of Resident # 30 care plan dated 12/17/23 revealed resident was on oxygen at 1-5 liters per minute via nasal cannula as needed for shortness of breath. The care plan interventions included to monitor for respiratory distress and report any shortness of breath, encourage frequent position changes for optimal breathing, observe for difficulty breathing (Dyspnea) on exertion, remind resident not to push beyond endurance and provide rest periods, observe for signs and symptoms of acute respiratory insufficiency: anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, somnolence, and report abnormal findings to the physician. Review of Resident #30's physician orders revealed no order for supplemental oxygen use. Record review was completed of Resident #30's skilled nursing notes and oxygen saturation levels from 1/3/24 to 2/20/24. The oxygen saturation	F 695	Resident #30 continues to receive oxygen administered per physician orders and documented per facility policy. Resident #30's physician order for oxygen was clarified on 2.20.24 by the Unit Manager. No negative outcome was identified relating to this observation. Current residents receiving oxygen have the potential to be affected. Current residents receiving oxygen were reviewed by the Unit Managers on 2.20.24 to ensure that they are receiving oxygen per physician orders and documented per facility policy. No negative outcomes were identified relating to these observations. All licensed nurses were inserviced by the ADON as of 2.29.24 on ensuring that oxygen is administered per physician orders and documented per facility policy. Any newly hired licensed nurses hired after 2.29.24 will receive the same education by the ADON prior to beginning their first shift on the floor. A QA monitoring tool will be utilized to ensure ongoing compliance by the Unit Manager/designee. The Unit Manager/designee will randomly observe 5 residents on oxygen 5x/week x 2 weeks, then 5 residents on oxygen 3x/week x 2 weeks, then 5 residents on oxygen weekly x 4 weeks then 5 residents on oxygen biweekly x 4 weeks to ensure that oxygen is administered per physician orders and documented per facility policy. Variances will be corrected at the time of observation	

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	345303	A. BUILDING _____ B. WING _____	C 02/27/2024

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F 695	Continued From page 37 entries indicated Resident #30 wore oxygen. Skilled nursing note documentation revealed Resident #30 wore oxygen and had shortness of breath when lying flat. An observation made on 2/20/24 at 3:12 PM revealed Resident #30 wearing oxygen at 2 liters per minute via nasal cannula administered by an oxygen concentrator unit. An interview on 2/20/24 at 3:49 PM with Nurse #3 confirmed Resident #30 wore supplemental oxygen. Nurse #3 stated orders for oxygen show up on the electronic medical administration record (e-MAR) and oxygen orders included how many liters of oxygen a resident was supposed to have or if the oxygen could be titrated. Nurse #3 reviewed the e-MAR for Resident #30 and was unable to locate oxygen orders for Resident #30. On 2/20/24 at 5:05 PM an interview was completed with Unit Manager (UM) #2. UM #2 stated if a resident wears oxygen and has oxygen in use there should be an order in place for oxygen. She explained the flow rate for oxygen liters would be part of the oxygen order. She stated she checked, and Resident #30 did not have an order for supplemental oxygen. She explained the order did not get carried over from a hospitalization. She stated Resident #30 was supposed to wear oxygen and she was unsure why the order did not get carried over. A follow-up interview was completed on 2/21/24 at 9:41 AM with UM #2. She stated the facility did not have standing orders. She explained if an oxygen order was needed, the nurse would contact the medical provider to obtain an order. UM #2 stated residents receiving supplemental	F 695	and additional education or corrective action provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 3.1.24	

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F 695	Continued From page 38	F 695		

oxygen had an oxygen saturation checked twice daily. She verified there was not an order in place to check Resident #30's oxygen saturation level.

A telephone interview was completed on 2/21/24 at 5:29 PM with Nurse #4. He verified Resident #30 wore supplemental oxygen. Nurse #4 stated he had not noticed that Resident #30 did not have an order for oxygen on her e-MAR prior to last night. He explained he was used to Resident #30 wearing oxygen because she had always worn supplemental oxygen. He stated Resident #30's oxygen was typically set at 2 liters per minute but was titrated based on her oxygen saturation level. He said if a resident was wearing oxygen and did not have an order, he would call the medical provider to obtain an order.

A phone interview was completed on 2/21/24 at 5:48 PM with the Medical Director. The Medical Director stated if a resident required oxygen there should be an order for oxygen and documentation of oxygen saturation level. He explained the liters of oxygen to be administered would be part of the oxygen order.

An interview was conducted on 2/22/24 at 3:45 PM with the Director of Nursing (DON). The DON stated the facility did not have standing orders. She explained the facility failed to carry over the oxygen order when Resident #30 returned from the hospital. She stated anyone with supplemental oxygen needed to have an order.

An interview was performed with the Administrator on 2/22/24 at 4:55 PM. The Administrator stated there should be an order in place for oxygen if a resident was using supplemental oxygen.

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F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		3/6/24

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F 842	Continued From page 40 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate medical records related to provision of supplements for 2 of 4 residents reviewed for nutrition (Resident #19 and Resident #12). The findings included: 1. Resident #19 was admitted to the facility on 9/13/16.	F 842	The facility will continue to maintain accurate medical records related to provision of nutritional supplements. Resident #19 and #12 continues to receive nutritional supplements per physicians order. No negative outcome was identified relating to this observation. Current residents with orders for nutritional supplements have the potential	

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F 842	Continued From page 41 A review of Resident #19's medical record indicated a physician's order dated 1/17/24 for a frozen nutritional supplement for weight loss two times a day with lunch and dinner. Resident #19's Medication Administration Record (MAR) for February 2024 indicated documentation through initials that the (frozen nutritional supplement) was given two times a day for weight loss at 12:00 PM and at 5:00 PM on 2/19/24, 2/20/24 and 2/21/24. An interview with Nurse #1 on 2/21/24 at 1:04 PM revealed Resident #19's frozen nutritional supplement was supposed to come with her meal tray from the kitchen but was not sure why it had not been there. Nurse #1 stated that he had documented on Resident #19's MAR on 2/19/24 at 5:00 PM and 2/20/24 at 12:00 PM without visualizing if the frozen nutritional supplement was on the tray. Nurse #1 further stated he just assumed that it was on Resident #19's meal tray. A phone interview with Nurse #2 on 2/22/24 at 10:38 AM revealed Nurse #1 told him that the frozen nutritional supplement came from the kitchen and to go ahead and sign for it on 2/20/24 at 5:00 PM without checking if it came on her supper tray. Nurse #2 stated he wasn't sure if Resident #19 received the frozen nutritional supplement on her supper tray on 2/20/24 and he did not go back to see how much was consumed. An interview with the Staff Development Coordinator (SDC) on 2/21/24 at 4:59 PM revealed she was pulled to work on the hall where Resident #19 resided. When asked why she signed for Resident #19's frozen nutritional supplement on 2/21/24 at 12:00 PM before	F 842	to be affected. Medical records for current residents with orders for nutritional supplements were reviewed by the Unit Managers on 2.21.24 to ensure that nutritional supplements were documented appropriately. No negative outcomes were identified relating to these observations. All dietary staff and licensed nurses were inserviced by the Registered Dietician and/or ADON as of 3.5.24 on ensuring that nutritional supplements are provided and documented per physician's orders. Any newly hired dietary staff, licensed nurses, and C N A's hired after 3.5.24 will receive the same education by the ADON prior to beginning their first shift on the floor. A QA monitoring tool will be utilized to ensure ongoing compliance by the Dietary Manager beginning on 3.6.24. The Dietary Manager will randomly observe meal trays of 5 residents 5x/week for 2 weeks, then 5 residents 3x/week x 2 weeks, then 5 residents weekly x 4 weeks, then 5 residents biweekly x 4 weeks to ensure that nutritional supplements are provided and documented per physician's orders. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during	

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F 842	Continued From page 42 Resident #19's lunch tray was delivered to her, the SDC stated she signed for it shorty before the lunch tray came out but Resident #19 did not receive a frozen nutritional supplement. The SDC stated when she gave Resident #19 a pain medication at around 3:30 PM, she gave her a cup of her frozen nutritional supplement. An interview with the Registered Dietician (RD) on 2/21/24 at 3:17 PM revealed she heard about the SDC signing off for Resident #19's frozen nutritional supplement even before her lunch tray came out. The RD stated that she knew the nurses were supposed to make sure that Resident #19 received her frozen nutritional supplement, but this was not realistic and practical for the nurses to be following up on the supplement which was supposed to be on the meal tray. An interview with the Director of Nursing on 2/22/24 at 3:40 PM revealed the nurses typically should look at Resident #19's meal tray to make sure she was receiving her frozen nutritional supplement. 2. Resident #12 was admitted to the facility on 4/7/17. A physician's order dated 2/14/23 for Resident #12 was on a pureed texture, regular consistency diet, frozen nutritional supplement at lunch, 2 handled cup and divided plate. The Medication Administration Record (MAR) showed that on 2/21/24 at 12:00 PM Nurse #5 signed that the frozen nutritional supplement was on the lunch tray.	F 842	monthly meetings. Continued compliance will be monitored through random medical records audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 3.6.24	

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F 842	Continued From page 43 Observations of Resident #12's lunch tray was observed on 2/19/24 at 1:07 PM, 2/20/24 at 12:54 PM and 2/21/24 at 12:49 PM and no frozen nutritional supplement was on the tray. The frozen nutritional supplement was listed on the tray ticket. During an interview on 2/21/24 at 2:20 PM with Nurse #5 it was revealed that he did sign off that Resident #12 received the frozen nutritional supplement on her lunch tray. The nurse did not check to ensure she received the frozen nutritional supplement and stated she usually got it and thought she did on 2/21/24. An interview with the Director of Nursing on 2/22/24 at 3:40 PM revealed the nurses typically should look at Resident #12's meal tray to make sure she was receiving her frozen nutritional supplement.	F 842		