STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 survey was conducted on 03/04/24 through 03/08/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID: 7FFE11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 03/04/24 through 03/08/24. Event ID 7FFE11. The following intakes were investigated: NC00212448, NC00211104, and NC00207106. Two (2) of the 6 allegations resulted in deficiency. Past noncompliance was identified at: CFR 483.12 at tag F606 at a scope and severity of K CFR 483.12 at tag F607 at a scope and severity of K The tags F606 and F607 constituted Substandard Quality of Care. A extended survey was conducted.	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.	F 578		3/30/24

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

Electronically Signed | 03/29/2024

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F 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure the code status information was accurate throughout the medical record for 3 of 19 residents (Resident #44, Resident #72 and Resident #140) reviewed for advanced directives. The findings included:	F 578	Criteria 1: On 3/6/24 when made aware of the discrepancies in code status in the medical record, the Director of Nursing (DON)/designee corrected the advanced directive information to reflect the correct code status throughout the medical record for resident #44, #72, and #140.	

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F 578	Continued From page 2 a. Resident #44 was admitted to the facility on 12/08/22. Review of the code status notebook that was maintained at the nursing desk revealed Resident #44 had a yellow Do Not Resuscitate (DNR) form dated 12/09/22 and an advanced directive for a Full Code signed on 01/05/18. A review of Resident #44's electronic health record (EHR) on 03/04/24 at 2:16 PM revealed an order for a DNR dated 12/09/22. The quarterly Minimum Data Set assessment dated 12/26/23 revealed Resident #44's cognition was moderately impaired. b. Resident #72 was admitted to the facility on 02/13/24. Review of the code status notebook that was maintained at the nursing desk. Resident #72 had a Do Not Resuscitate order for DNR dated 02/13/24 in the notebook. A review of Resident #72's electronic health record (EHR) on 03/04/24 at 2:33 PM revealed an order for Full Code dated 02/13/24. The admission Minimum Data Set assessment dated 02/19/24 revealed the Resident's cognition was moderately impaired. c. Resident #140 was admitted to the facility on 02/28/24. A review of the Nursing Admission Assessment dated 02/28/24 revealed Resident #140 was alert and oriented to person, place, time and situation.	F 578	Criteria 2: On 3/6/24, an audit of all advanced directives was completed by the DON/designee to ensure that code status was accurate in all areas of the medical record. Upon completion of this audit, no additional discrepancies were noted. Criteria 3: On 3/28/24, The DON/designee completed education with all nurses, the Director of Social Services, and the Medical Records Director that all areas of the medical record must reflect accurate information about advanced directives and correlate with the physician□s order for code status. The new process for obtaining advanced directives will be to reference the electronic medical record for code status. The binder located at the nurse station will be storage only for the yellow Do Not Resuscitate (DNR) and Medical Orders for Scope of Treatment (MOST) forms. All newly hired staff will be educated upon hire prior to accepting an assignment. Criteria 4: The DON or designee will audit all residents 2 x week x 4 weeks and weekly x 4 weeks to ensure that advanced directive information is accurate throughout the medical record and that only the Medical Order for Scope of Treatment (MOST) forms and yellow DNR	

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F 578	Continued From page 3 Review of the code status notebook maintained at the nursing desk. Resident #140 had a Resuscitation order for Cardiopulmonary (CPR) signed by the Resident on 02/28/24. Also, in the code status notebook was a pink Medical Order for Scope of Treatment (MOST) dated 01/19/24 signed by Resident #140. A review of Resident #140's electronic health record (EHR) on 03/04/24 at 2:07 PM revealed an order for a Full Code dated 02/28/24. An interview was conducted with the Social Worker (SW) on 03/05/24 at 1:24 PM. The SW explained that she had been employed by the facility for 3 years and had a very limited role in the advanced directive process. She explained that when the resident was admitted to the facility, she checked the face sheet and whatever the advanced directive was determined which care plan she developed for the resident. The SW continued to explain that when a resident's advanced directive changed the nursing department informed her and she made the adjustment to the care plan. An interview was conducted with Unit Manager (UM) #1 on 03/05/24 at 1:34 PM. The UM explained that the two Unit Managers were responsible for admissions and double checked each other for orders that included the advanced directives. She continued to explain that after the resident was admitted they addressed the advanced directive with the resident or their representative and completed the facility's paperwork according to their desire. The UM stated after the completion of the paperwork they gave it to the Medical Records Director who	F 578	forms are stored in the binder for nursing to access. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee. The Medical Records Director is responsible for this plan of correction. Criteria 5: Date of compliance is 3/30/24.	

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F 578	Continued From page 4 placed it in the code status notebook at the nursing desk. The UM also indicated Medical Records was responsible for auditing the two records to ensure that they matched. On 03/05/24 at 2:13 PM during an interview with the Medical Records Director she explained that the Admissions Director of the Unit Managers were responsible for completing the advanced directive paperwork and then it was given to her to scan into the residents' medical records, and she would place it in the code status notebook at the nursing desk. She stated she audited the code status notebook every week, but she did not realize how often the code status changed and did not know that she was supposed to ensure the code status in the notebook matched the code status in the residents' medical record. During an interview with the Director of Nursing (DON) on 03/08/24 at 9:23 AM the DON explained that the unit managers were responsible for obtaining the advanced directives from the residents or their representatives after the residents were admitted and the Admissions Director was responsible for completing the paperwork. The DON indicated the Medical Records Director should be auditing the code status notebook but sometimes a nurse would be assigned to do it because of the frequent transfers to the hospital.	F 578		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		3/30/24

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F 583	Continued From page 5 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to safeguard protected health information (PHI) for 8 of 8 residents (Residents #7, #10, #11, #55, #72, #77, #85 and #91) observed for privacy and confidentiality, by leaving confidential PHI exposed on an unattended medication cart in an area accessible to the public.	F 583	Criteria 1: To correct deficient practice for resident confidentiality of records, the staff member who failed to use appropriate privacy protocol was immediately reeducated on 3/11/24 by the Director of Nursing (DON) on privacy policies and	

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F 583	Continued From page 6 The finding included: During a continuous observation made on 03/06/24 at 9:06 AM through 9:08 AM Nurse #1 walked away from the 100 hall medication cart and left a report sheet uncovered which exposed the PHI of residents names and room numbers of Resident #7, #10, #11, #55, #77, #85 and #91. The PHI included information of code status, vital signs, medications, diets, diagnoses, continent status and safety precautions. During the observation three staff members and one visitor passed by the medication cart. An interview was conducted with Nurse #1 on 03/06/24 at 9:08 AM. The Nurse acknowledged she left the report sheet exposed and explained that she normally laid a sheet of paper over the report sheet before she left the medication cart but forgot to do it that morning. On 03/07/24 at 12:57 PM during an interview with the Director of Nursing (DON) she explained that the facility had laminated covers that were supposed to be used to cover the report sheets. The DON stated it looked like she needed to come up with something different to ensure the staff protected the PHI of the residents.	F 583	procedures that include prohibiting view of resident information in areas accessible to the public to safeguard residents protected health information. Criteria 2: An observation audit of facility staff was completed on 3/28/24 by the DON/designee to identify any additional staff not compliant with privacy policies. During this audit, no additional infractions were found. Criteria 3: On or before 3/28/24, the DON or designee will educate all staff all staff on facility privacy policies that protected health information will not be disclosed or displayed in a manner that allows view by the public and that it is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure. Newly hired staff will be educated upon hire prior to accepting an assignment. Criteria 4: The DON or designee will monitor compliance with privacy and confidentiality policies by completing an observation audit of facility staff 5 x weekly x 8 weeks. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee	

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F 583	Continued From page 7	F 583	until substantial compliance is achieved and agreed upon by the QAPI committee. The DON is responsible for this plan of correction. Criteria 5: Date of compliance is 3/30/24.	
F 602 SS=G	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, Police Officer, and Health Care Personnel Investigator interviews the facility failed to protect the resident's right to be free from misappropriation of resident property when Nurse Aide (NA) #1 allegedly stole a wallet and $320.00 from Resident #27. Resident #27 stated he felt like he was taken advantage of, and it really bothered him that she (NA #1) would do something like that. Resident #27 become tearful as he stated that he did not want this to happen to anyone else. This deficient practice affected 1 of 3 residents reviewed abuse, neglect, and misappropriation of resident property. The findings included:	F 602	Past noncompliance: no plan of correction required.	

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F 602	Continued From page 8	F 602		

Resident #27 was readmitted to the facility on 08/19/22.

A quarterly Minimum Data Set (MDS) dated 10/06/23 revealed that Resident #27 was cognitively intact, had no signs of delirium and no behaviors.

An initial allegation report dated 12/14/23 read in part, Nurse Aide (NA) #1 had been accused of misappropriation of Resident #27's property. He stated that she came into his room late one evening and the next morning his wallet was missing from his locked drawer. NA #1 was suspended pending the investigation and Resident #27's belongings secured in a locked drawer and safe. Local law enforcement were notified. The report was signed by the former Administrator.

The five working day report dated 12/21/23 indicated that Resident #27 identified NA #1 from the previous night as the accused individual. Local law enforcement through the magistrate office issued an arrest warrant and NA #1 was arrested for exploitation of elderly/handicap individual. NA #1 was accused of stealing $320.00 and a $30.00 wallet. The allegation was substantiated, and NA #1 was terminated on 12/21/23.

An observation and interview were conducted with Resident #27 on 03/04/24 at 11:02 AM. Resident #27 was sitting up in his wheelchair and was noted to have a purple lanyard around his neck that had two keys on it. Resident #27 stated that he kept the key to the top nightstand drawer along with the key to his safe that sat on top of his nightstand on the lanyard around his neck.

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F 602	Continued From page 9	F 602		

Resident #27 explained that on 12/13/23 NA #1 was in his room assisting his roommate and when she was done, she came to Resident #27's bedside and asked to borrow a dollar so she could get a snack. Resident #27 stated he told NA #1 he had snacks in his drawer, and she was welcome to them, but NA #1 was insistent that she wanted to borrow a dollar to get a snack out of the vending machine. Resident #27 stated that he handed NA #1 the key to the top drawer of his nightstand so that she could hand him his wallet and she did. Resident #27 explained that he kept both of his wallets in a black zipper pouch and in one wallet he kept dollar bills in and the other one he kept larger bills. After he had gotten the dollar bill out of his wallet, he put the wallet back in the black zipper pouch and handed it to NA #1 and asked her to please lock it back up in the top drawer of his nightstand. He added that NA #1 simulated putting the zipper pouch in the drawer and then emphasized to Resident #27 that she had locked the drawer and pulled on it to show that it was locked. Resident #27 stated that he never saw NA #1 put the zipper pouch/wallet in the drawer and the following morning when he got up, he went straight to the drawer and the zipper pouch/wallet was gone. Resident #27 explained that he was certain that it was NA #1 that took his wallet because that night he never went back to sleep and no one else came in his room that night. He added that another staff member had found the zipper pouch/wallet in another resident's room a week ago but the #320.00 cash was gone, his bank card and social security card were still in the wallet, but his cash was gone. Resident #27 explained that NA #1 had not been back into his room since this event and the only time he had seen her since 12/14/23 was when he went to court on two separate occasions for

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F 602	Continued From page 10	F 602		

her hearing which was continued. He added he would be going back to court for a third time on 03/27/24.
Resident #27 stated the on 12/14/23 he reported the incident to the former Administrator and since then he purchased a small safe to keep on top of his nightstand to keep his personal affects in.

A follow up interview was conducted with Resident #27 on 03/06/24 at 9:38 AM. Resident #27 stated that having his money and wallet stolen "made me feel like she took advantage of me. For a while I was very bothered by it because I thought she was an all-right girl." Resident #27 stated that the wallet was in a black zipper pouch and all the cash was gone except there was a secret compartment that NA #1 did not know about and there was 14.00 in there that she did not take but the other cash she took. He added that eventually the facility replaced his cash and now he kept his wallet in the safe that was purchased after the event. Resident #27 stated "I have been to court 2 times, and I would rather be doing something else besides sitting in the court room. I have to go back to court again" on 03/27/24. "I feel like my things are safe here as long as they are locked up in my safe." Resident #27 became tearful and stated, "thank you for looking into this I don't want this to happen to anyone else."

An attempt to speak to NA #1 was made on 03/05/24 at 2:04 PM and was unsuccessful.

The former Administrator was interviewed via phone on 03/05/24 at 2:29 PM and again on 03/05/24 at 5:01 PM, he stated that on 12/14/23 he was notified that Resident #27 wanted to speak to him. He stated he spoke to Resident

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F 602	Continued From page 11	F 602		

#27 who reported he thought that NA #1 had stolen his wallet during the night of 12/13/23. Resident #27 explained that NA #1 asked him to borrow a dollar and he had given her the key to his drawer to unlock it and hand him his wallet so he could give her a dollar and then he asked NA #1 to lock the wallet back up in the drawer, but he did not see her put the wallet in the drawer before she locked it. At the time he reported the incident to the former Administrator Resident #27 was able to describe NA #1, but she was working in the building that day and when NA #1 walked by Resident #27 he stated "that is the girl" that took my wallet. The Administrator stated that they immediately suspended NA #1 and began an investigation. The former Administrator stated at the end of the investigation they ended up terminating NA #1 in December 2023 based on the direct witness statement of Resident #27 and then a couple of days later we got notified that she (NA #1) had been arrested and charged.

The Health Care Personnel Investigator (HCPI) was interviewed via phone on 03/05/24 at 4:06 PM, she stated that she was assigned the case involving NA #1 that allegedly occurred in the facility on 12/13/23. The Investigator further explained that NA #1 had outstanding criminal charges of misdemeanor larceny and exploitation of elderly person and was scheduled to be back in the court system on 03/27/24 and once the case was through the court system her registry information would be updated accordingly depending on the outcome of the case. She added that she had spoken to NA #1 via phone, and she denied the allegations and stated she had absolutely no reason why she was arrested and charged. The HCPI stated that the Director of Nursing (DON) had notified her that on 02/22/24

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Resident #27's wallet had been found in another resident's room who spent all of her time in bed and was blind. She added that NA #1's case was still under investigation, and she was still attempting to speak to the Policer Officer that responded to the call on 12/14/23.

NA #3 was interviewed on 03/06/24 at 9:58 AM, explained that on 02/22/24 she was working on Resident #27's unit and was making an incontinent round as usual. She stated she went into a female resident room to provide care to her, and her hearing device was squealing. The female resident's roommate stated that if the hearing device was squealing that meant the batteries were dead and her family had kept extra batteries in her nightstand. NA #3 stated she went ahead and provided care and got the resident situated and then opened her second drawer of her nightstand and there was a black zipper pouch. She stated she assumed that was where the extra batteries were kept and so she opened the black zipper pouch and when she opened it there was 2 wallets, one was green and black, and the other one was all black and when she opened the green and black one it had Resident #27's driver's license in it. NA #3 stated that she closed the wallet and put it back inside the zipper pouch and took it to the DON.

The Police Officer that responded to the facility on 12/14/23 was interviewed via phone on 03/08/24 at 5:39 PM. He stated that he responded to a call from the facility on 12/14/23 and when he arrived, he met with the former Administrator and then spoke to Resident #27. He stated that Resident #27 told him that NA #1 had asked him to borrow a dollar and he had given her the key to unlock his nightstand drawer

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and hand him his wallet and when he asked her to lock it back up, she had locked the drawer but he had not seen her put the wallet in the drawer before locking it and he was certain no one else had been in his room that night and the key remained on a lanyard around his neck. The Policer Officer stated that after he spoke to Resident #27, he had gone to the magistrate on Resident #27's behalf and had a probable cause hearing and warrant to continue investigating the case. He stated that a few days later NA #1 was arrested and charged with larceny and exploitation of an elderly person. The Police Officer stated that on 03/04/24 he had spoken at the grand jury hearing about NA #1 and the case was continued and she was due in court again on 03/27/24. He added that NA #1 still had 3 pending felony charges and 3 pending misdemeanor charges that she was being tried for.

The DON was interviewed on 03/05/24 at 5:49 PM, she stated that on 12/14/23 Resident #27 reported to the former Administrator that he believed NA #1 had stolen his wallet during the night of 12/13/23 and so an investigation was started. The DON stated that the former Administrator handled most of the investigation, but she made sure Resident #27 was in court on both court dates. The DON explained that NA #1 was terminated in December 2023 because when they re-verified her nurse aide registry listing it came back with substantiated findings that occurred after she was hired, and she had not disclosed that to us. The DON also stated that on 02/22/24 NA #3 found Resident #27's zipper pouch/wallet in another resident room but his cash was gone. After the event on 12/13/23, the facility had interviewed the alert and oriented residents about exploitation and all staff were

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educated on the abuse, neglect, and misappropriation policy. In addition, the facility initiated a valuable sheet that was required to be filled out with 2 staff signatures and resident signature anytime a resident asked the staff to purchase something with their money. The plan was introduced into the quality assurance meeting on 12/19/23. Ongoing audits of the valuable sheets were done two times monthly until directed by the QA team.

The facility provided the following corrective action plan with a completion date of 12/18/23. All items on this self-imposed plan have been implemented on 12/14/23 and completed on 12/18/23 with ongoing monitoring to ensure compliance. This concludes the action plan and any potential citation associated with this plan should be considered past noncompliance as of 12/18/23.

Corrective action that will be accomplished:

On 12/14/23 Administrator provided affected resident with a safe for valuable items.

On 12/14/23 Administrator educated this resident (BIMS 14) on how to secure valuables/money in the lockable drawers in the nightstand in his room, in the Business office, and in the new safe.
Identification of other residents:

All residents who keep valuables/money are at risk of the same deficient practice.

Starting on 12/14/23, an audit was conducted by Administrator/designee where all residents with BIMS of 10 or greater were interviewed and questioned regarding exploitation and any

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concerns related to exploitation. Any concerns were addressed.

Measures for system change:

On or before 12/18/23, all staff were educated by the Administrator/all on abuse, neglect, and exploitation with an emphasis on exploitation and correct measures for interaction with residents related to money and valuables.

On or before 12/18/23, all staff will be educated by the Administrator/designee on the new process that any staff member asked to assist any resident with money or valuable will be required to have a witness and complete an Audit sheet to any actions taken when it relates to resident's valuables/money.

On or before 12/18/23, all residents with BIMS of 10 or greater were educated on how to secure valuables/money in the lockable drawer in the nightstand in their room or in the business office.

How corrective action will be monitored:

All activity with staff involvement related to valuables/money will be documented with signatures required by the resident, a staff member, a witness, and a Nurse Manager/Admin staff and returned to the Administrator or DON for record keeping purpose. This audit tool will be reviewed monthly x 2 months as part of QAPI process. The QAPI team will consider any changes to the process at that time.

The corrective action plan was validated on 03/08/24. Resident #27 was verbally able to describe how and where he locked up his

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F 602	Continued From page 16 personal affects. Interviews with other alert and oriented residents also revealed that they were aware of how and where to lock up with personal affects. Staff interviews across all departments revealed that all staff were aware of the newly implemented process for handing resident money, and the requirement of having witness signatures and resident signatures and the need to turn them into the Administrator or DON. Initial audit of residents with BIMS of 10 or higher was reviewed and observations of resident's nightstand drawer with the lockable device were reviewed with no issues noted. The resident council was also educated on how and where to lock up their belongings and were educated on abuse, neglect, and exploitation. The plan went to the QA meeting on 12/19/23 and the ongoing audits of the valuable sheets were reviewed with no issues noted. The compliance date of 12/18/23 was validated.	F 602		
F 606 SS=K	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or	F 606		

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F 606	Continued From page 17 misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Health Care Personnel Investigator (HCPI) interviews the facility failed to terminate and allowed Nurse Aide (NA) #1 to continue to work after becoming aware that she had substantiated findings of misappropriation of resident property which occurred while NA #1 was employed in a nursing facility and had a substantiated finding of fraud against a resident which occurred while NA #1 was employed in a nursing facility on the North Carolina Nurse Aide Registry on 08/15/23. NA #1 was terminated on 12/21/23 following an investigation of misappropriation of Resident #27's property that allegedly occurred in the facility on 12/13/23. This deficient practice of allowing NA #1 to continue to work had the high likelihood to affect other residents. The findings included: Review of NA #1's employee file revealed she was hired by the facility on 03/09/23. The employee file had an "Orientation Checklist" that indicated a registry verification had been completed as well as her background check. The employee file contained no verification identification number (number you get when you verify a nurse aide registry listing). The file contained a background check that was completed on 03/10/23 and revealed no	F 606	Past noncompliance: no plan of correction required.	

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reportable court records found.

Further review of NA #1's employee file revealed a North Carolina Nurse Aide 1 Registry verification completed on 08/15/23 with a confirmation number provided that indicated that NA #1 "has 1 substantiated finding of Misappropriation of Resident Property which occurred while the individual was employed in a Nursing Facility. This information was entered on the Registry on 04/17/23." The verification further indicated that NA #1 "has 1 substantiated finding of fraud against a resident which occurred while the individual was employed in a Nursing facility. This information was entered into the registry on 04/17/23."

The former Human Resource Director was interviewed via phone on 03/05/24 at 4:26 PM, she explained that she worked for the company for a year and half. The former Human Resource Director stated that when she hired new Nurse Aides, she would always run their name and social security number through the Nurse Aide Registry system and then would enter their listing number and expiration date into the facility's onboarding system. She stated she did not retain the original verification, only entered the needed information into their onboarding system. She explained she was preparing to leave the facility to pursue other opportunities and that included uploading all the Nurse Aide information into the facility's electronic onboarding system and during that time she re-verified that all the Nurse Aide's registry information was valid. She stated that was when she discovered that NA #1 had findings of misappropriation and fraud on her registry listing, and she had not disclosed that information upon hire. The former Human Resource director

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stated that she had verified her registry listing information upon hire and there was nothing there and her background check was clean as well. She stated that after she made the discovery in August 2023, she took the information to the former Administrator who was also preparing to leave, and "we sent the information" to the Corporate Human Resource Director and also notified the District Director of Operations. She stated that NA #1 was terminated in December 2023 after an allegation of misappropriation of resident property but could not say what the outcome of reporting to the Corporate Human Resource Director and District Director of Operations was in August 2023.

The former Administrator was interviewed via phone on 03/05/24 at 2:29 PM and again on 03/05/24 at 5:01 PM, he stated that on 12/14/23 he was notified that Resident #27 wanted to speak to him. He stated he spoke to Resident #27 who reported he thought that NA #1 had stolen his wallet during the night of 12/13/23. Resident #27 explained that NA #1 asked him to borrow a dollar and he had given her the key to his drawer to unlock it and hand him his wallet so he could give her a dollar and then he asked NA #1 to lock the wallet back up in the drawer, but he did not see her put the wallet in the drawer before she locked it. At the time Resident #27 reported the incident to the former administrator he was able to describe NA #1, but she was working in the building that day and when NA #1 walked by Resident #27 he stated "that is the girl" that took my wallet. The Administrator stated that they immediately suspended NA #1 and began an investigation. The former Administrator stated at the end of the investigation they ended up terminating NA #1 in December 2023 based on

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the direct witness statement of Resident #27 and then a couple of days later the former Administrator got notified that she had been charged and arrested. The former Administrator stated that he was only notified of NA #1's registry findings during the investigation of Resident #27's missing wallet and money, he stated had he known earlier about the finding's that were on NA #1's registry listing they would have immediately separated employment with NA #1. He further added that he recalled that the registry listing that he was aware of was not a conviction but was listed as a pending charge or an "accusation."

The District Director of Operations was interviewed via phone on 03/05/24 at 4:51PM, he stated that he was aware of the situation with NA #1. He stated he could not speak to the timing of the discovery but what he recalled was that during the investigation of Resident #27's missing wallet and money they re-verified NA#1's registry listing which was part of their routine practice and discovered that after she was hired, she had something on her registry listing. When they discovered that NA #1 had something on her registry listing, he had the staff re-verify everyone to ensure that no one else had anything on their registry listing. The District Director of Operations stated that the former Human Resource director never shared with him the Nurse Aide registry findings in August 2023, or he would have separated employment with NA #1 at that time.

The Corporate Human Resource Director was interviewed via phone on 03/06/24 at 10:53 AM, she stated that she had not started with the company until September 2023 and was not aware of registry findings for NA #1 until December 2023 when she was terminated from

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the company. She confirmed that if anything came back on the NA registry, the information would be shared with her and the decision would made to separate employment and if the findings had anything to do with a resident in a nursing facility it would be grounds for immediate termination.

The Health Care Personnel Investigator (HCPI) was interviewed via phone on 03/05/24 at 4:06 PM, she stated that she was assigned the case involving NA #1 that allegedly occurred in the facility on 12/13/23. She explained that NA #1 had another case involving misappropriation of resident property and fraud against a resident that was opened on 11/15/22 and the decision to substantiate was made on 03/01/23. At the time that decision was made the North Carolina Nurse Aide Registry would have been updated to reflect those findings. She continued to say that if the facility had verified NA #1's registry listing on 03/09/23 which was her date of hire the findings of misappropriation and fraud against a resident would have been pending but would have been present on her registry verification and the facility should not have hired her. Once the appeal process was over the pending findings would have been changed to substantiated, which they did so on 04/17/23. The HCPI further explained that NA #1 had outstanding criminal charges of misdemeanor larceny and exploitation of elderly person and was scheduled to be back in the court system on 03/27/24 and once the case was through the court system her registry information would be updated accordingly depending on the outcome of the case.

The Director of Nursing (DON) was interviewed on 03/05/24 at 5:49 PM, she stated that on

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12/14/23 Resident #27 reported to the former Administrator that he believed NA #1 had stolen his wallet during the night of 12/13/23 and so an investigation was started. The DON stated that when NA #1 was hired they verified her registry listing and there was nothing on it but during the investigation of Resident #27's missing wallet and money they re-verified her registry listing and found that she had something on her registry listing. The DON stated that if that came up after we hired NA #1, she felt like she (NA #1) should have disclosed that information to us and that was why we terminated her in December 2023. The DON stated that the former Administrator handled most of the investigation, but she made sure Resident #27 was in court on both court dates. She stated that she was unaware of the registry listing that was pulled in August 2023 and that had she known she would have immediately separated employment with NA #1.

The Administrator and DON were notified of immediate jeopardy on 03/06/24.

The facility provided the following corrective action plan with a completion date of 12/22/23:

All licensed staff and certified staff were re-verified through NC Nurse Aid Registry and NC Board of Nursing Registry for any substantiated findings for any abuse/misappropriation, by the Director of Nursing. Completed on 12/21/23

Identification of other Residents:

No other staff were identified with negative findings on the re-verification (re-verification was completed by the Director of Nursing running the licensure/certification off the nurse aid registry

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and the Board of Nursing registry)

Measures for Systemic Change:

All new hires will be verified to ensure no substantiated findings on their license/ certification for abuse/misappropriation, by the Human Resource (HR) Director or Director of Nursing prior to employment, upon renewal of licensure/certification and prn with allegations, any negative findings will be brought to the Administrator and Director of Nursing to review. HR Director receives a report monthly with upcoming license and certification renewals. If any substantiated findings are noted the HR Director will notify Administrator and Corporate HR for direction related to the employee's employment. HR Director was informed of this requirement and process by the Administrator on 12/20/23.

How Corrective Action will be Monitored:

On 12/20/23 monitoring of this process was implemented following review by QA on 12/19/23.

HR Director or Director of Nursing will run reports from NC Nurse Aid registry and NC Board of Nursing Registry for all licensed and certified staff monthly X 6 months, and randomly thereafter to ensure that no staff have substantiated findings on their records. All new hires will be verified by HR Director or Director of Nursing prior to employment, upon renewal and prn with any allegations. The Administrator and/or Director of Nursing will review the reports for compliance. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting with the QAPI

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F 606	Continued From page 24 Committee responsible for ongoing compliance. Date of compliance: 12/22/23 The corrective action plan was validated on 03/08/24. The verification of all Nurse Aide registry listing information and Board of Nursing verification were reviewed with no other issues noted. All newly hired nurse aide and nurses since 12/22/23 have been verified through either the Nurse Aide registry or Board of Nursing and those verifications were reviewed with no further issues noted. The facility had no allegations of abuse, neglect, or misappropriation of resident property since 12/22/23. The facility has re-verified all nurse aide listings and nursing license for staff monthly since 12/22/23, those were reviewed with no negative findings noted. Interviews with the Human Resource director and administrative staff revealed that they were aware that all nurse aide registry and nursing license were to be verified monthly, with renewal, and with any allegation of abuse, neglect, or misappropriation of resident property that the employee was involved with. The corrective action plan was taken to the Quality Assurance meeting on 12/19/23. The facility's compliance date of 12/22/23 was validated.	F 606		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		

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F 607	Continued From page 25 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their abuse policy by failing to separate employment of Nurse Aide (NA) #1 on 08/15/23 when the facility became aware that she had substantiated findings of misappropriation of resident property and fraud against a resident that occurred while the individual was employed in a nursing facility. NA #1 continued her employment with the facility until 12/21/23 when she was terminated following an allegation of misappropriation of resident property. This deficient practice affected 1 of 3 residents (Resident #27) reviewed for abuse, neglect, and misappropriation of resident property and had the high likelihood to affect other	F 607	Past noncompliance: no plan of correction required.	

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residents in the facility. The census at the time of the survey was 86 residents.

The findings include:

Review of a facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated 03/28/23 read in part, Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law, had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property, or a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property.

Review of NA #1's employee file revealed she was hired by the facility on 03/09/23. The employee file had an "Orientation Checklist" that indicated a registry verification had been completed as well as her background check. The orientation checklist had been completed by the former Human Resource Director. The employee file contained no verification identification number (number you get when you verify a nurse aide registry listing). The file contained a background check that was completed on 03/10/23 and revealed no reportable court records found.

Further review of NA #1's employee file revealed a North Carolina Nurse Aide I Registry verification completed on 08/15/23 with a confirmation number provided that indicated that NA #1 "has 1

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substantiated finding of Misappropriation of Resident Property which occurred while the individual was employed in a Nursing Facility. This information was entered on the Registry on 04/17/23." The verification further indicated that NA #1 "has 1 substantiated finding of fraud against a resident which occurred while the individual was employed in a Nursing facility. This information was entered into the registry on 04/17/23."

The former Human Resource Director was interviewed via phone on 03/05/24 at 4:26 PM. The former Human Resource Director stated that when she hired new Nurse Aides, she would always run their name and social security number through the Nurse Aide Registry system and then would enter their listing number and expiration date into the facility's onboarding system. She stated she did not retain the original verification, only entered the needed information into their onboarding system. She explained that she was preparing to leave the facility to pursue other opportunities and part of preparing to leave the facility included uploading all the Nurse Aide information into the facility's electronic onboarding system and during that time she re-verified that all the Nurse Aide's registry information was valid. She stated that was when she discovered that NA #1 had findings of misappropriation and fraud on her registry listing, and she had not disclosed that information upon hire. The former Human Resource director stated that she had verified her registry listing information upon hire and there was nothing there and her background check was clean as well. She stated that after she made the discovery in August 2023, she took the information to the former Administrator who was also preparing to leave, and the information was

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sent to the Corporate Human Resource Director and also notified the District Director of Operations. She stated that NA #1 was terminated in December 2023 after an allegation of misappropriation of resident property but could not say what the outcome of reporting to the Corporate Human Resource Director and District Director of Operations was in August 2023.

An initial allegation report dated 12/14/23 read in part, Nurse Aide (NA) #1 had been accused of misappropriation of Resident #27's property. He stated that she came into his room late one evening and the next morning his wallet was missing from his locked drawer. NA #1 was suspended pending the investigation and Resident #27's belongings secured in a locked drawer and safe. Local law enforcement were notified. The report was signed by the former Administrator.

The five working day report dated 12/21/23 indicated that Resident #27 identified NA #1 from the previous night as the accused individual. Local law enforcement through the magistrate office issued an arrest warrant and NA #1 was arrested for exploitation of elderly/handicap individual. NA #1 was accused of stealing $320.00 and a $30.00 wallet. The allegation was substantiated, and NA #1 was terminated on 12/21/23.

The former Administrator was interviewed via phone on 03/05/24 at 2:29 PM and again on 03/05/24 at 5:01 PM, he stated that on 12/14/23 he was notified that Resident #27 wanted to speak to him. He stated he spoke to Resident #27 who reported he thought that NA #1 had stolen his wallet during the night of 12/13/23.

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Resident #27 explained that NA #1 asked him to borrow a dollar and he had given her the key to his drawer to unlock it and hand him his wallet so he could give her a dollar and then he asked NA #1 to lock the wallet back up in the drawer, but he did not see her put the wallet in the drawer before she locked it. At the time Resident #27 reported the incident to the former administrator he was able to describe NA #1, but she was working in the building that day and when NA #1 walked by Resident #27 he stated "that is the girl" that took my wallet. The Administrator stated that they immediately suspended NA #1 and began an investigation. The former Administrator stated at the end of the investigation they ended up terminating NA #1 in December 2023 based on the direct witness statement of Resident #27 and then a couple of days later the former Administrator got notified that she had been charged and arrested. The former Administrator stated that he was only notified of NA #1's registry findings during the investigation of Resident #27's missing wallet and money, he stated had he known earlier about the finding that were on NA #1's registry listing they would have immediately separated employment with NA #1 per the facility policy. He further added that he recalled that the registry listing that he was aware of was not a conviction but was listed as a pending charge or an "accusation."

The District Director of Operations was interviewed via phone on 03/05/24 at 4:51PM, he stated that he was aware of the situation with NA #1. He stated he could not speak to the timing of the discovery but what he recalled was that during the investigation of Resident #27's missing wallet and money they re-verified NA#1's registry listing which was part of their routine practice and

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discovered that after she was hired, she had something on her registry listing. When they discovered that NA #1 had something on her registry listing, he had the staff re-verify everyone to ensure that no one else had anything on their registry listing. The District Director of Operations stated that the former Human Resource director never shared with him that registry findings in August 2023 or he would have separated employment with NA #1 at that time per their facility policy.

The Corporate Human Resource Director was interviewed via phone on 03/06/24 at 10:53 AM, she stated that she had not started with the company until September 2023 and was not aware of registry findings for NA #1 until December 2023 when she was terminated from the company. She confirmed that if anything came back on the NA registry the information would be shared with her and the decision would made to separate employment and if the findings had anything to do with a resident in a nursing facility it would be grounds for immediate termination per their policy.

The Director of Nursing (DON) was interviewed on 03/05/24 at 5:49 PM, she stated that on 12/14/23 Resident #27 reported to the former Administrator that he believed NA #1 had stolen his wallet during the night of 12/13/23 and so an investigation was started. The DON stated that when NA #1 was hired they verified her registry listing and there was nothing on it but during the investigation of Resident #27's missing wallet and money they re-verified her registry listing and found that she had something on her registry listing. The DON stated that if that came up after we hired NA #1, she felt like she (NA #1) should

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have disclosed that information to us and that was why we terminated her in December 2023. The DON stated that the former Administrator handled most of the investigation, but she made sure Resident #27 was in court on both court dates. She stated that she was unaware of the registry listing that was pulled in August 2023 and that had she known she would have immediately separated employment with NA #1 per their policy.

The Administrator and DON were notified of Immediate jeopardy on 03/06/24 1:08 PM.

The facility provided the following corrective action plan with a completion date of 12/22/23:

F607 Failure to Implement Abuse policy.
CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:
On 12/20/2023, The Facility Administrator was notified by The Human Resources Director of adverse action on North Carolina Nurse Aide Registry for an employee suspended on 12/14/2023.

On 12/20/2023, The Facility Administrator addressed the failure to follow abuse policy by providing education to The Human Resource Director on the abuse policy and following the process for monitoring the NC Nurse Aid Registry and the NC Board of Nursing Registry to ensure no adverse action noted on staff members licenses/certifications.

On 12/21/2023, the employee with adverse findings was terminated from the facility by Director of Nursing.

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IDENTIFICATION OF OTHER RESIDENTS:

All residents have the potential to be affected. On 12/21/23, all current licensed and certified facility staff were re-verified through North Carolina Nurse Aide Registry (NCNAR) and NC Board of Nursing Registry for any adverse finding or action by the DON with no additional employees noted with adverse actions. No other negative findings noted.

MEASURES FOR SYSTEMIC CHANGE:

In addition to pre-hire verification, licensed and certified employees will be verified by the Human Resources director or the DON against the NCNAR and NC Board of Nursing Registry upon license or certification renewal, and in the event of an abuse allegation. Facility administrator educated human resource director to this process on 12/20/2023. Human Resource director and director of nursing receive monthly reports of upcoming license and certification renewals. Abuse allegations involving facility staff are communicated to human resources by administrator or director of nursing.

On 12/20/2023 The Human Resources Manager was made aware of this monitoring process by the Facility Administrator. A new HR Manager was hired on 1/3/2024 and was educated on this process by the Corporate HR Director.

On 12/21/2023, enhanced education was added by the corporate Human Resources director to new hire orientation for any new human resources employees regarding policy and notification of any adverse findings on NCNAR

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F 607	Continued From page 33 checks and NC Board of Nursing Registry. HOW CORRECTIVE ACTION WILL BE MONITORED: As of 12/21/2023, The Human Resource Manager or Director of Nursing will run reports from the NC Nurse Aid Registry and the NC Board of Nursing Registry for all licensed and certified staff monthly to ensure that no staff have substantiated findings on their records. On 12/20/2023 monitoring of this process was implemented following review by QA on 12/19/23. The Administrator and/or Director of Nursing will review the reports for compliance. Results of these audits will be reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting with the QAPI Committee responsible for ongoing compliance. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. Date of Compliance 12/22/2023 The corrective action plan was validated on 03/08/24. The verification of all nurse aide registry listing information and Board of Nursing verification were reviewed with no other issues noted. All newly hired nurse aide and nurses since 12/22/23 have been verified through either the nurse aide registry or Board of Nursing and those verifications were reviewed with no further issues noted. The facility had no allegations of abuse, neglect, or misappropriation of resident	F 607		

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F 607	Continued From page 34 property since 12/22/23. The facility had re-verified all nurse aide listings and nursing license for staff monthly since 12/22/23, those were reviewed with no negative findings noted. Interviews with the Human Resource director and administrative staff revealed that they were aware that all nurse aide registry and nursing license were to be verified monthly, with renewal, and with any allegation of abuse, neglect, or misappropriation of resident property that the employee was involved with. The corrective action plan was taken to the Quality Assurance meeting on 12/19/23. The facility's compliance date of 12/22/23 was validated.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately code the Minimum Data Set assessments in the areas of discharge and lower extremity impairment for 1 of 2 discharged residents and 1 of 1 resident reviewed for choices (Resident #89 and Resident #1). The findings included: 1. Resident #89 was admitted to the facility on 01/04/24. Review of Resident #89's discharge Minimum Data Set assessment dated 02/02/24 revealed he was discharged from the facility with a return	F 641	Criteria 1: The assessment for resident #89 was modified by the Minimum Data Set (MDS) Coordinator when the error was identified and corrected on 3/8/24. The modified assessment accurately reflected the resident□s discharge disposition. The assessment for resident #1 was modified by the MDS Coordinator when the error was identified and corrected on 3/20/24. The modified assessment accurately reflected the resident□s limitation with lower extremity mobility. Criteria 2:	3/30/24

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F 641	Continued From page 35 anticipated. Additional review of the discharge Minimum Data Set assessment revealed Resident #89 was coded as being discharged to his home or back into the community. Review of progress notes revealed a progress note dated 02/02/24 that read, in part: "Resident and wife insisted that resident discharge from facility today due to copays ... Unable to convince them to stay and continue rehabilitation. Home health set up ..." An interview with MDS Nurse #2 on 03/08/24 at 12:03 PM revealed she had coded the discharge inaccurately. MDS Nurse #2 reported "Oh my, that's wrong." and reported she would correct the discharge status of Resident #89 and resubmit the Minimum Data Set assessment. An interview with the Director of Nursing on 03/08/24 at 12:21 PM revealed she expected Minimum Data Set assessments to be completed accurately and thoroughly. She verified that Resident #89 was discharged home without an expected return and his discharge Minimum Data Set assessment should have reflected that. 2. Resident #1 was admitted to the facility on 05/11/19 with diagnoses that included paraplegia. Review of Resident #1's annual Minimum Data Set assessment dated 12/18/23 revealed Resident #1 was cognitively intact. Resident #1 was coded with no impairment to her lower extremity and required substantial or maximal assistance with lower body dressing. Resident #1 was dependent on others for putting on and taking off footwear.	F 641	An audit of all current residents discharged in the last 30 days will be completed by an MDS Coordinator on or before 3/29/24 to ensure that discharge disposition is accurately reflected on the most recent MDS. On or before 3/29/24, a second audit was completed by an MDS Coordinator of all current residents with an MDS transmitted in the last 30 days to ensure that lower extremity mobility is accurately coded on the most recent MDS. Any additional incorrect assessments found will be corrected as applicable. Criteria 3: On or before 3/29/24, MDS Coordinators were educated by the Regional MDS Nurse on the need to ensure that after review of the resident□s condition, that the coded data is consistent with information in the progress notes, plan of care, and resident observations and interviews for discharge disposition and lower extremity mobility. Criteria 4: Through review of MDS assessments ready for export, the MDS Coordinator will audit 5 assessments per week x 8 weeks to ensure that the resident□s lower extremity impairment is coded accurately. Through review of MDS assessments for discharged residents, the MDS Coordinator will also audit all MDS□s for	

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F 641	Continued From page 36 An observation an interview of Resident #1 on 03/08/24 at 9:07 AM revealed her to be in her wheelchair propelling herself with her arms towards the activity room. Resident #1 reported due to her medical diagnoses, she had no feeling or control of her lower body. She reported she required total assistance with bathing and dressing her lower half. Resident #1 reported the only movement she had in her legs were occasional involuntary spasms. An interview with MDS Nurse #2 on 03/08/24 at 11:46 AM, she stated she reviewed therapy notes and read diagnoses to determine limitations to an extremity. She reported she had coded the Minimum Data Set with no impairment due to a physical therapy note that reported no issues with range of motion. MDS Nurse #2 then reviewed the Resident Assessment Instrument manual for instructions on coding of impairments and reported "she can't do that, it's incorrect." MDS Nurse reported she would correct the annual Minimum Data Set assessment to accurately reflect Resident #1's lower extremity limitation and resubmit it. An interview with the Director of Nursing on 03/08/24 at 12:21 PM revealed she agreed that Resident #1 had a limitation to lower extremity and reported she expected it to be accurately reflected on Resident #1's Minimum Data Set assessments.	F 641	discharged residents each week x 8 weeks to ensure discharge disposition is coded accurately. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee. The MDS Coordinator is responsible for this plan of correction. Criteria 5 Date of compliance is 3/30/24.	
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	F 656		3/30/24

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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 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

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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 656	Continued From page 38 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 observations, record reviews and staff interviews, the facility failed to implement a care plan intervention for a non slip mat on a resident's wheelchair used to prevent the resident from sliding for 1 of 3 residents (Resident #23) reviewed for accidents. The finding included: Resident #23 was admitted to the facility on 05/16/18 with diagnoses that included Parkinson disease. The quarterly Minimum Data Set (MDS) assessment dated 12/04/23 revealed Resident #23 was cognitively intact and the behavior of rejection of care was not exhibited. The MDS indicated that the Resident had functional limitations of range of motion of upper and lower extremities on both sides and the mode of mobility was a wheelchair. She was incontinent and required set up assistance for transfers. Resident #23 had one fall since the previous assessment on 09/04/23. A review of an Incident Report dated 01/24/24 revealed Resident #23 had an unwitnessed fall and was found lying on her back on the floor and stated she was trying to get to the bathroom. Resident #23's care plan revised on 01/25/24 indicated she was at high risk for falls extensive assistance with activities of daily living, weakness and poor decision making. The goal that her risk	F 656	Criteria 1 On 3/6/24, resident #23 was interviewed about the non-slip mat on her wheelchair to ensure understanding of the use of the non-slip mat. Resident #23 has an understanding of the intervention but stated she removes it for better mobility while in her wheelchair. Care Plan was updated on 3/6/24 stating Dycem in wheelchair as resident allows. Criteria 2 On or before 3/29/24, the Director of Nursing (DON) or designee completed an audit of falls in the last 30 days to ensure that all interventions were in place as documented in the care plan. No other incidents of failure to implement a Care Plan intervention were identified. Criteria 3 On or before 3/29/24, DON or designee educated licensed nurses, Certified Nursing Assistants (CNA□s) and department managers that when fall interventions are developed in response to a fall, the interventions are to be placed in effect by the nurse managers or appropriate member of the interdisciplinary team immediately. During review of the falls in the clinical stand	

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	345080	A. BUILDING _____ B. WING _____	C 03/08/2024

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and potential for injury will be minimized through utilization of interventions such as keeping the call light in reach and encouraging her to use it, conducting frequent rounds of toileting assistance, wearing gripper socks, keeping personal items near the Resident, applying anti roll back brakes and utilizing a non slip mat in her wheelchair.

A review of an Incident Report dated 03/01/24 revealed Resident #23 had an unwitnessed fall while attempting to transfer to her wheelchair from her bed. The report indicated the Resident most likely hit her head as evidence of swelling to the right side of her head. Neuro checks were initiated and were within normal limits.

An observation and interview conducted with Resident #23 on 03/04/24 at 12:36 PM revealed the Resident was sitting in her wheelchair beside her bed. The Resident was asked if she had a non slip mat in her wheelchair and the Resident replied "no" while lifting her buttocks up to show there was not a non slip mat in her wheelchair.

During an observation and interview with Resident #23 on 03/05/24 at 12:20 PM, the Resident was observed rolling herself in her wheelchair out of the bathroom and parked beside her bed. The Resident was asked if there was a non slip mat in her wheelchair to help prevent her from sliding out of the wheelchair and the Resident appeared to not understand what she was being asked. Upon inspection, there was no non slip mat in her wheelchair.

An observation was made on 03/05/24 at 3:04 PM of Resident #23 sleeping in her bed with her wheelchair parked beside her bed. There was not

down meeting, the DON will verify that the intervention was implemented. Newly hired staff will be educated upon hire prior to accepting an assignment.

Criteria 4

The Director of Nursing or designee will audit all falls each week to ensure interventions are in place as documented on the care plan. The audits will be completed weekly x 8 weeks and will be reviewed by the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee.

Criteria 5

Date of compliance is 3/30/24.

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F 656	Continued From page 40	F 656		

a non slip mat in her wheelchair.

Interviews were conducted with Nurse Aide (NA) #1 and Medication Aide (MA) #1 simultaneously on 03/05/24 at 3:05 PM. The NA confirmed she cared for Resident #23 on 03/04/24 and 03/05/24 and explained she was not aware of the Resident's recent fall on 03/01/24 and did not know the interventions put in place to prevent further falls. The NA stated the non slip mat would probably be on her Kardex (care plan for the nurse aides), but she did not know because although she was assigned to care for Resident #23 that day, she did not work with Resident #23 often. The NA explained that fall interventions would be on the Resident's Kardex, but she had not reviewed the Resident's Kardex. MA #1 confirmed she worked with Resident #23 on 03/05/24 and explained that she was not aware that a non slip mat should be in the Resident's wheelchair and stated the Resident would probably not leave the mat in her wheelchair. NA #1 and MA #1 were accompanied to the Resident's Kardex and the non slip mat was listed on the Kardex as an intervention to her falls.

During an interview with the Minimum Data Set Nurse #1 on 03/05/24 at 3:31 PM the Nurse explained that the Incident Reports were reviewed the in the morning during the clinical meeting and the interventions were determined and added to the updated care plan which will roll over onto the Kardex. She indicated it was the nurse aides' responsibility to review the Kardex for the added interventions.

On 03/06/24 at 4:51 PM during an interview with Unit Manager (UM) #2 the UM confirmed Resident #23 had a history of falls and explained

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F 656	Continued From page 41 the Resident continued to transfer herself even with frequent reminders not to get up by herself. UM #2 explained the ability for the Resident to safely transfer herself varied from day to day because of her diagnosis. The UM continued to explain that several interventions had been put in place to prevent the Resident from falling and the last one was a non slip mat in her wheelchair. She stated the staff should ensure there was a non slip mat in the Resident's wheelchair every day and indicated if the Resident did not leave the non sliding mat in her wheelchair, then it should be reported so another intervention could be determined. An interview was conducted with the Director of Nursing (DON) on 03/08/24 at 10:08 AM. The DON explained that Resident #23 would often remove the non sliding mat from her wheelchair and stated it looked like they needed to add "if resident allowed" to the non slip mat intervention on her care plan.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to keep a dependent resident's fingernails clean and trimmed for 1 of 2 residents reviewed for activities of daily living (Resident #51). The findings included:	F 677	Criteria 1 On 3/5/24, 2024, nurse aide #5 trimmed and cleaned resident #51□s fingernails. Criteria 2	3/30/24

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F 677	Continued From page 42 Resident #51 was admitted to the facility on 01/03/20 with diagnoses that included seizures, major depressive disorder, and adjustment disorder. Review of Resident #51's annual Minimum Data Set assessment dated 09/01/23 revealed Resident #51 was independent with eating and required extensive assistance with 2 or more persons, physical assistance with personal hygiene. Review of Resident #51's quarterly Minimum Data Set assessment dated 02/02/24 revealed resident had moderately impaired cognition with no delirium, no behaviors, or rejection of care. Review of Resident #51's care plan, last updated on 02/20/24 revealed a care plan for "[Resident #51 has an ADL (activities of daily living) self-care performance deficit related to impaired balance, incontinence, refusal of care (showers, nail care, and incontinent care), and generalized weakness." Interventions included to encourage active participation in tasks. An observation of Resident #51 on 03/04/24 at 11:21 AM revealed his fingernails to extend ¼ inch past the tip of his finger. The nails on Resident #51's right hand was observed to have an orange and black substance underneath them from the tip of his finger to the edge of the nail. An interview with Resident #51 on 03/04/24 at 11:24 AM revealed he did not trim his own nails and relied on facility staff to clean and trim them. Another observation of Resident #51 was	F 677	An audit of all residents fingernails was conducted on 3/27/24 by licensed nurses. Care was provided to all residents with fingernails that needed cleaning and trimming. Criteria 3 On or before 3/28/24, the DON or designee educated all licensed nurses on accuracy of weekly skin assessments, which includes the condition of fingernails and the need for nail care. Education also completed with all Certified Nursing Assistants (CNAs) that included the expectation for completion of nail care during shower time and the proper chain of command for follow-up on nail care issues that need to be addressed by a licensed nurse. Newly hired licensed nurses and CNAs will be educated upon hire and prior to accepting a resident assignment. Criteria 4 Th DON or designee will audit all resident fingernails 2 x weekly x 2 weeks and 1 x weekly for 6 weeks to ensure that all residents fingernails are clean and well-trimmed. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee. The Director of Nursing (DON) is responsible for this plan of correction.	

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F 677	Continued From page 43	F 677	Criteria 5 Date of compliance is 3/30/24.	

completed on 03/04/24 at 1:45 PM. He was still in his room and had finished his lunch meal tray. Resident #51's nails were observed to be in the same condition as they were earlier in the day with the same orange and black substance underneath them.

An observation of Resident #51 was completed on 03/05/24 at 8:23 AM. Resident was in his room eating his breakfast tray. Resident #51 was using his fingers on his right hand at times to feed himself. His nails remained in the same condition as the prior day with an orange and black substance underneath the nails on his right hand.

Another observation of Resident #51 was completed on 03/06/24 at 8:28 AM. Resident #51 was in his bed asleep with his breakfast tray in front of him with his right hand resting on his plate. Resident #51's nails were observed to be clean and neatly trimmed.

Review of the facility's shower schedules revealed Resident #51 was scheduled for a shower on Wednesdays and Saturdays on 2nd shift. There was also a label on Sunday for "nail care day".

Review of facility working schedules revealed Nurse Aide #3 and Nurse Aide #4 (NA #3 and NA #4) worked with Resident #51 on his previous 2 shower days.

On 03/08/24 at 12:45 an interview with NA #3 who worked with Resident #51 on Wednesday, 2/28/24 was attempted by telephone. There was no answer, and a message was unable to be left.

An interview with NA #4 on 03/07/24 at 4:11 PM

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F 677	Continued From page 44 revealed she had worked with Resident #51 on Saturday, March 1st and had offered him a shower but he requested a bed bath instead. NA #4 reported she provided the bed bath and stated she cleaned his fingernails. NA #4 stated she remembered Resident #51's nails being "very dirty" with food caked underneath them. She reported his nails were not trimmed. She did not believe them to be long. NA #4 stated she cleaned Resident #51's nails but did not trim them. NA #4 also reported that Resident #51 occasionally ate his meals with provided utensils but that he mainly used his fingers to eat. An interview with NA #5 on 03/08/24 at 1:12 PM, she verified she worked with Resident #51 on 03/05/24 and she was the staff member who cleaned and trimmed Resident #51's nails on 03/05/24. She reported she was scheduled to do nail care that day and she went to Resident #51's room sometime after breakfast. She reported when she observed his nails, she noticed they were long and very dirty underneath. She reported she was able to clean and trim Resident #51's nails without any issues. During an interview with the Director of Nursing on 03/08/24 at 12:21 PM she reported she could see that the observed orange and black substance under Resident #51's nails as being food. She also reported that resident fingernails should be addressed on their shower days, every Sunday, and as needed. She reported she was unsure about the process for gathering resident preferences on the length of nails they wished to have, but that there should never be substance left under the nails.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		3/30/24

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F 695	Continued From page 45 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 reviews and interviews the facility failed to post cautionary and safety signs that indicated the use of oxygen for 2 of 3 residents (Resident #6 and Resident #58) reviewed for respiratory care. The findings included: a. Resident #6 was admitted to the facility on 02/14/24. The admission Minimum Data Set assessment dated 02/20/24 revealed Resident #6's cognition was severely impaired. Review of Resident #6's physician orders revealed an order dated 02/28/28 for continuous oxygen at 2 liters per minute via nasal cannula. A review of Resident #6's 02/2024 and 03/2024 Medication Administration Records (MAR) revealed the Resident received continuous oxygen at 2 liters per minute via nasal cannula since 02/28/24. On 03/04/24 at 11:50 AM an observation was	F 695	Criteria 1 On 3/6/24, the Director of Nursing (DON) placed cautionary oxygen signs on the outer door frames for residents #6 and #58. Criteria 2 On or before 3/21/24, the DON or designee completed an audit of all residents to ensure that any resident with oxygen in the room had a cautionary oxygen sign on the outer frame of the door. There were no other residents with oxygen missing the cautionary oxygen sign identified. Criteria 3 On or before 3/15/24, the DON or designee educated all licensed nurses that any resident who is receiving oxygen must have safety signage posted that indicates the use of oxygen. Oxygen signs are in the oxygen storage room and	

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F 695	Continued From page 46 made of Resident #6 lying in bed sleeping. The Resident was wearing an oxygen cannula with oxygen delivered at 2 liters per minute. There was no oxygen cautionary signage posted to indicate oxygen was in use. Subsequent observations made on 03/05/24 at 12:16 PM and 03/06/24 at 9:03 AM revealed Resident #6's oxygen infusing via at nasal cannula. There was no cautionary oxygen signage posted to indicate oxygen was in use. An interview was conducted with Medication Aide (MA) #1 on 03/06/24 at 9:07 AM. The MA explained that neither the medication aides nor the nurse aides had any responsibility pertaining to the residents' oxygen and stated the only task they could do regarding the oxygen was to replace the cannula or masks. The MA indicated there should be a cautionary oxygen in use sign posted on the resident's doorframe but did not know who was responsible for posting the sign. During an interview with Unit Manager (UM) #2 on 03/06/24 at 9:17 AM the UM explained that whoever the nurse was that initiated the oxygen should post the cautionary oxygen signage on the residents' doorframe and the nurse responsible for the hall should monitor for the signs. An interview was conducted with the Assistant Director of Nursing (ADON) on 03/07/24 at 11:57 AM. The ADON explained that the unit managers and the nurses should be monitoring for the oxygen signs to be posted when they work with the residents. She continued to explain that they had several residents that removed the signs and that was all the more reason for the staff to be vigilant for the signs to be posted on the	F 695	should be placed on the door by the licensed nurse when oxygen is issued to a resident. All newly hired staff will be educated upon hire prior to accepting an assignment. Criteria 4 The DON or designee will audit all residents with oxygen 2 x weekly x 8 weeks to ensure that that the cautionary oxygen signs are in place. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee. Criteria 5 Date of Compliance is 3/30/24.	

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doorframes.

On 03/08/24 at 9:34 AM during an interview with the Director of Nursing, she explained the receptionist was responsible for hanging the cautionary oxygen signs on the residents' doorframes when they were admitted. She indicated the nurse managers should be monitoring the oxygen signs when they make rounds on the halls.

b. Resident #58 was admitted to the facility on 08/09/23 with diagnoses that included chronic obstructive pulmonary disease (COPD).

A review of Resident #58's physician orders dated 12/02/23 revealed continuous oxygen at 3 liters per minute via nasal cannula.

The quarterly Minimum Data Set assessment dated 12/27/23 revealed Resident #58's cognition was moderately impaired, and she received supplemental oxygen.

A review of Resident #58's Medication Administration Record (MAR) dated 03/2024 indicated the Resident received continuous oxygen at 3 liters per minute via nasal cannula.

An observation was made of Resident #58 on 03/04/24 at 1:15 PM. The Resident was lying in bed sleeping with supplemental oxygen being delivered via nasal cannula at 3 liters per minute. There was no oxygen cautionary signage posted to indicate oxygen was in use in the Resident's room.

Subsequent observations made on 03/05/24 at 12:10 PM and 03/06/24 at 9:00 AM revealed

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Resident #58 received supplemental oxygen via nasal cannula at 3 liters per minute. There was no oxygen cautionary sign posted near the Resident's room to indicate that oxygen was in use.

An interview was conducted on 03/06/24 at 9:06 AM with Nurse #1. The Nurse acknowledged there was no oxygen sign posted on Resident #58's doorframe and explained the receptionist was responsible for posting the oxygen signs outside the residents' door when they were admitted on oxygen.

During an interview with Unit Manager (UM) #2 on 03/06/24 at 9:17 AM the UM explained that whoever the nurse was that initiated the oxygen should post the cautionary oxygen signage on the residents' doorframe and the nurse responsible for the hall should monitor for the signs.

An interview was conducted with the Assistant Director of Nursing (ADON) on 03/07/24 at 11:57 AM. The ADON explained that the unit managers and the nurses should be monitoring for the oxygen signs to be posted when they work with the residents. She continued to explain that they had several residents that removed the signs and that was all the more reason for the staff to be vigilant for the signs to be posted on the doorframes.

On 03/08/24 at 9:34 AM during an interview with the Director of Nursing, she explained the receptionist was responsible for hanging the cautionary oxygen signs on the residents' doorframes when they were admitted. She indicated the nurse managers should be monitoring the oxygen signs when they make

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F 695	Continued From page 49 rounds on the halls.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, consultant pharmacist, and Medical Director interviews the facility failed to maintain a medication error rate of less than 5% by having 2 errors out of 28 opportunities which resulted in a 7.14% medication error rate. This affected 2 of 6 residents observed on medication pass (Resident #39 and Resident #93). The findings included: 1. Resident #39 was readmitted to the facility on 01/22/23 with diagnoses that included end stage renal disease. A physician order dated 08/22/23 read Lanthanum Carbonate (used to keep phosphorus levels down in dialysis residents) 1000 milligrams (mg) by mouth with meals for end stage renal disease. A quarterly Minimum Data Set (MDS) dated 02/07/24 indicated that Resident #39 was cognitively intact and received dialysis during the assessment reference period. An observation of Medication Aide (MA) #2	F 759	Criteria 1 On 3/7/24, the Medical Director was notified of medication errors for residents #39 and #93. The medication errors were reviewed by the Medical Director for residents #39 and #93 to ensure that no harm had occurred related to #39 receiving a medication without a meal and #93 receiving a higher dose of Vitamin D than what was ordered. The Medical Director determined that no harm would occur from these isolated incidents. On 3/11/24, the Director of Nursing (DON) or designee completed education with MA #2 and nurse #1 on the 10 Rights of Medication Administration. Criteria 2 On or before 3/28/24, the DON or designee, using a Medication Pass audit tool, observed all licensed nurses and Certified Medication Aides (CMAs) administer medications. No additional medication errors were observed.	3/30/24

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F 759	Continued From page 50 preparing Resident #39's medication was made on 03/06/24 at 4:04 PM. The medications that were prepared included Lanthanum Carbonate 1000 mg 1 tablet. After MA #2 had prepared Resident #39's medications she proceeded to his room and handed him the cup that contained the Lanthanum Carbonate tablet. Resident #39 was observed to sit up in bed and take the cup and put the Lanthanum Carbonate tablet in his mouth and chew it up. There was no meal on the unit or in Resident #39's room. MA #2 did not offer a snack or meal to Resident #39 before she exited the room. MA #2 was interviewed on 03/07/24 at 10:18 AM, she stated that Resident #39's lanthanum carbonate was scheduled on the Medication Administration Record (MAR) before the mealtime. She explained that the medication was scheduled to be given at 4:00 PM but the meal on that unit was not supposed to be delivered until 6:15 PM. MA #2 stated she was aware that she had an hour before and an hour after the scheduled medication time to administer the medication and she had done that. The Consultant Pharmacist was interviewed via phone on 03/07/24 at 12:19 PM, she stated that taking Lanthanum Carbonate on an empty stomach did not affect absorption, but it should be given with food to avoid gastrointestinal (GI) adverse effects. She explained that during the limited study done on the medication it was given with food to increase compliance and decrease the discontinued rate of the medication. And for that reason, it was best to give with food to avoid the GI effects and increase compliance of the medication.	F 759	Criteria 3 On or before 3/26/24, the DON or designee educated all licensed nurses and CMAs on the 10 Rights of Medication Administration. Newly hired staff will be educated upon hire prior to accepting an assignment. . Criteria 4 The DON or designee will observe all licensed nurses and CMA□s monthly x 2 months using the Medication Pass audit tool to ensure that safe administration of medications to residents is occurring. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee. Criteria 5 Date of compliance is 3/30/24.	

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The Medical Director was interviewed on 03/07/24 at 11:31 AM who stated that taking the Lanthanum Carbonate without food would probably not sit well for his GI tract or stomach but that would probably be the extend of the effects of taking the medication on an empty stomach.

The Director of Nursing (DON) was interviewed on 03/07/24 at 12:46 PM, she stated that she believed that the staff were nervous during the medication pass observation but stated that they should be following the physician orders.

2. Resident #93 was admitted to the facility on 02/23/24 with diagnosis that vitamin D deficiency.

A physician order dated 02/23/24 read Cholecalciferol (Vitamin D) oral tablet 25 mcg (1000 units) by mouth in the morning for vitamin D deficiency.

An admission Minimum Data Set (MDS) dated 03/01/24 revealed that Resident #93 was moderately cognitively impaired.

An observation of Nurse #1 preparing Resident #93's medication was made on 03/07/24 at 9:10 AM. The medications included Vitamin D3 125 micrograms (mcg) 5000 units one tablet. After Nurse #1 had prepared all of Resident #93's medication she proceed to his room to administer the cup of medications and then exited the room and returned to her medication cart.

Nurse #1 was interviewed on 03/07/24 at 9:57 AM, she stated that she was aware that the physician order indicated 1000 units "but instead of not giving anything I gave the 5000 units."

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Nurse #1 explained that the bottle of 5000 units was all that she had available on her cart, and in the past when she has contacted the pharmacy about medications, they instruct her to purchase the medication over the counter. Nurse #1 stated she believed it was cheaper to get it over the counter then have the pharmacy dispense it.

The Medical Director (MD) was interviewed on 03/07/24 at 11:31 AM, he stated "I do not feel good about her logic" referring to Nurse #1. He explained that getting 5000 units one time would have no immediate effects, but long term could result in Vitamin D toxicity. The MD stated that there was no signs or symptoms to look for in Vitamin D toxicity and would be detected on a blood test.

The Consultant Pharmacist was interviewed via phone on 03/07/24 at 11:47 AM, she stated that getting 5000 units of Vitamin D instead of 1000 units would have no adverse effects unless the resident was receiving 50,000 units weekly and then was given additional high doses throughout the week. The Consultant Pharmacist stated that she "had no issues with the resident being given 5000 units instead of 1000 units because the residents are so vitamin deficient from being inside constantly, they have so much room to have additional vitamin D." She further explained that Resident #93 had no major kidney issues, and the Vitamin D was good for him, and she would argue that he may need an increased dose of Vitamin D but we would need to check his level just to be on the safe side.

The Director of Nursing (DON) was interviewed on 03/07/24 at 12:46 PM, she stated that she believed that the staff were nervous during the

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F 759	Continued From page 53 medication pass observation but stated that they should be following the physician orders.	F 759		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to	F 849		3/30/24

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provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

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(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those

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residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a

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F 849	Continued From page 57 description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Hospice Nurse interviews the facility failed to obtain a physician order for hospice services for 1 of 1 resident (Resident #44) reviewed for hospice. The finding included: Resident #44 was admitted to the facility on 12/08/22 with diagnoses that included cerebral vascular disease. During an interview with the Hospice Nurse on 03/05/24 at 10:43 AM the Nurse indicated Resident #44 began hospice services on 07/07/23 for cerebral vascular disease. The quarterly Minimum Data Set (MDS) assessment dated 12/26/23 revealed Resident #44's cognition was moderately impaired and was coded as having a condition or chronic disease that may result in a lift expectancy of less than 6 months. The Resident was also coded as receiving hospice services. A review of Resident #44's physician order revealed no active order for hospice services. A review of Resident #44's care plan revised on 01/04/24 for a terminal prognosis related to cerebral vascular disease. The goal for his dignity and autonomy to remain at the highest level would be attained by adjusting the provisions of his activities of daily living to compensate for his	F 849	Criteria 1 On 3/5/24, the Director of Nursing (DON) obtained an order from the provider to support Hospice services for resident #44 Criteria 2 On on or before 3/28/24, the Director of Nursing completed an audit of all residents currently on hospice services to ensure that an order was present to support hospice services. Any issues found were corrected. Criteria 3 On or before 3/28/24, the Director of Nursing completed education with all licensed nurses regarding the requirement for a physician□s order for hospice services on any resident who will receive hospice care. The process is that if a hospice order is received by a licensed nurse, the order must immediately be placed in PCC by the nurse receiving the order. Newly hired licensed nurses will be educated upon hire and before accepting a resident assignment. Criteria 4 The DON or designee will audit all	

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F 849	Continued From page 58 changing abilities and having hospice services. An interview was conducted with the Assistant Director of Nursing (ADON) on 03/07/24 at 11:55 AM. The ADON explained that Resident #44 had been on and off hospice and in and out of the hospital several times and it was possible that a new order was not obtained when he returned from the hospital. The ADON stated it should be everyone's responsibility to audit the hospice orders.	F 849	residents receiving hospice services 1 x weekly x 8 weeks to ensure that a physician's order is present for each resident under hospice care. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee. The Director of Nursing (DON) is responsible for this plan of correction. Criteria 5 The date of compliance is 3/30/24.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		3/30/24

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not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to

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ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)

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F 867	Continued From page 61 functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 03/25/21 and 11/17/22 and for the complaint investigation conducted on 11/09/21. This failure was for eight deficiencies that were originally cited in the areas of Resident Rights (F578) and (F583), Freedom from Abuse, Neglect, and Exploitation (F607), Quality of Care (F695), Quality of Life (F677), Resident Assessment (F641), and Comprehensive Resident Centered Care plan (F656), and Infection Control (F880) that were subsequently recited on the current recertification and complaint investigation survey of 03/08/24. The repeat deficiencies during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to:	F 867	Criteria 1: The Greens at Viewmont received repeat citations of F 578/F 583 (Resident Rights), F 607 (Freedom from Abuse, Neglect and Exploitation), F 641 (Resident Assessment), F 656 (Comprehensive Resident Centered Care Plan), F 677 (Quality of Life), F 695 (Quality of Care) and F 880 (Infection Control) during our annual survey which had been cited on our prior survey in the past 3 years. Revised plans have been developed to address Resident Rights, Freedom from Abuse, Neglect and Exploitation, Resident Assessment, Comprehensive Resident Centered Care Plans, Quality of Life, Quality of Care and Infection Control with ongoing monitoring by the Quality Assurance and Performance Improvement Committee. Criteria 2: All residents have the potential to be affected. Root Cause Analysis was	

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F 867	Continued From page 62 F578: Based on record reviews and staff interviews, the facility failed to ensure the code status information was accurate throughout the medical record for 3 of 19 residents (Resident #44, Resident #72 and Resident #140) reviewed for advanced directives. During the recertification and complaint survey of 03/25/21 the facility failed to maintain accurate advance directives throughout the medical records for 2 of 18 residents reviewed for advance directives. F583: Based on observations and staff interviews, the facility failed to safeguard protected health information (PHI) for 8 of 8 residents (Residents #7, #10, #11, #55, #72, #77, #85 and #91) observed for privacy and confidentiality, by leaving confidential PHI exposed on an unattended medication cart in an area accessible to the public. During the recertification and complaint survey of 03/25/21 the facility failed to provide privacy while providing incontinence care for 1 of 1 resident reviewed for privacy. F607: Based on record review and staff interviews the facility failed to implement their abuse policy by failing to separate employment of Nurse Aide (NA) #1 on 08/15/23 when the facility became aware that she had substantiated findings of misappropriation of resident property and fraud against a resident that occurred while the individual was employed in a nursing facility. NA #1 continued her employment with the facility until 12/21/23 when she was terminated following an allegation of misappropriation of resident property. This deficient practice affected 1 of 3	F 867	completed by the Interdisciplinary Quality Assurance Team for F578, F583, F607, F641, F656, F677, F695 and F 880 to determine the systemic break that led to the deficient practice with revised plans to address. Criteria 3: Education was provided on 3/28/24 to the Quality Assurance and Performance Committee (QAPI) consisting of the Administrator, Director of Nursing, Dietary Manager, Housekeeping/Laundry Supervisor, Activity Director, Social Worker, Infection Preventionist, Medical Director and Therapy Director by the Administrator. Education included review of the Quality Assurance and identifying areas of Performance Improvement, Root Cause Analysis and monitoring of Plans for improvement. Criteria 4: The Administrator will conduct monthly Quality Assurance Performance Improvement Meetings to review and monitor all active Performance Plans for compliance. Any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. The Regional Nurse attend quarterly QAPI meetings and will review all monthly QAPI minutes x 6 months and to ensure that the Committee is maintaining implemented procedures/interventions to prevent	

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F 867	Continued From page 63 residents (Resident #27) reviewed for abuse, neglect, and misappropriation of resident property and had the high likelihood to affect other residents in the facility. The census at the time of the survey was 86 residents. During the complaint investigation on 11/09/21 the facility failed to implement their abuse and neglect policy in the area of reporting injuries of unknown origin when a Resident was observed with bruising to her neck for 1 of 3 residents reviewed for supervision to prevent accidents. F641- Based on observations, record review and staff interviews, the facility failed to accurately code the Minimum Data Set assessments in the areas of discharge and lower extremity impairment for 1 of 2 discharged residents and 1 of 1 resident reviewed for choices. (Resident #89 and Resident #1). During the recertification and complaint survey of 03/25/21 the facility failed to accurately code the Minimum Data Set Assessment for the presence of a pressure ulcer and a significant weight loss (for 2 of 2 residents reviewed for falls. F656: Based on observations, record reviews and staff interviews, the facility failed to implement a care plan intervention for a non-slip mat on a resident's wheelchair used to prevent the resident from sliding for 1 of 3 residents (Resident #23) reviewed for accidents. During the recertification and complaint survey of 03/25/21 the facility failed to develop a care plan for an indwelling urinary catheter and failed to implement the care plans for catheter stabilizing devices for 2 of 3 residents reviewed for indwelling urinary catheters.	F 867	recurring non-compliance. Criteria 5: Date of Compliance is 3/30/24.	

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F 867	Continued From page 64 F677: Based on observations, record review, and staff interviews, the facility failed to keep a dependent resident's fingernails clean and trimmed for 1 of 2 residents reviewed for activities of daily living. (Resident #51). During the recertification and complaint survey of 03/25/21 the facility failed to provide routine incontinence care to a resident with a Stage IV pressure ulcers to the sacrum and to provide nail care to a dependent resident who was observed to have long, sharp, and jagged fingernails with dark color debris underneath the nails for 1 of 5 resident reviewed for activities of daily living (ADL). F695: Based on observations, record reviews and interviews the facility failed to post cautionary and safety signs that indicated the use of oxygen for 2 of 3 residents (Resident #6 and Resident #58) reviewed for respiratory care. During the recertification and complaint survey of 11/17/22 the facility failed to administer the prescribed rate of oxygen for 2 of 5 residents sampled for respiratory services. F880: Based on observations, record review and staff interviews, the facility failed to implement their infection control policy when Nurse Aide #3 did not handle soiled linen in a sanitary manner and did not perform hand hygiene after completing incontinence care for 1 of 2 observations of infection control. During the recertification and complaint of 03/25/21 the facility failed to follow the "Enhanced Droplet Isolation" sign posted on the door of 2 of	F 867		

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F 867	Continued From page 65	F 867		

14 residents that were on Enhanced droplet isolation by not donning a gown before entering the resident rooms on the quarantine unit. Additionally, a staff member failed to remove her gloves and perform hand hygiene when exiting 1 of 14 residents that were on Enhanced Droplet Precautions. These failures occurred during a global pandemic.

The Administrator was interviewed on 03/08/24 at 11:08 AM, she stated that she had only been at the facility for 3 weeks and had the opportunity to have one QA meeting. She explained normally she would direct the QA meeting but since this was her first meeting the Director of Nursing had assisted in coordinating the meeting. The Administrator stated that all department heads in the facility attended the monthly meeting along with the Medical Director and consultant pharmacist either by phone or in person. She explained that during the QA meeting they discussed on-going performance improvement plans to see if they can be resolved or need to be amended or changed. We also discuss ongoing education and educational needs of the facility staff, we discuss grievances, work orders, weight loss, wounds, falls, infection control, maintenance logs, pharmacy reviews, and other topics that the team brings up. The Administrator stated she had done interim work for a lot of different companies and this one was ran "like a well-oiled machine" due to the tenure of the staff in the building. She added that a good thing that she brought to the table was she had lots of experience in different setting and situation and sometimes those things were successful in other building and if needed she could try them in this one. The Administrator stated she had good audit and tracking tools and a stable DON and that alone was helpful in

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F 867	Continued From page 66 correcting and maintaining long-term compliance.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		3/30/24

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F 880	Continued From page 67 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement their infection control policy when Nurse Aide #3 did not handle soiled linen in a sanitary manner and did not perform hand hygiene after completing incontinence care for 1 of 2 observations of infection control.	F 880	Criteria 1 On 3/26/24, Director of Nursing (DON) or designee educated CNA #3 on appropriate and sanitary management of soiled linen, proper glove usage, and handwashing between residents.	

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F 880	Continued From page 68 The finding included: The facility's policy "Handwashing/Hand Hygiene" dated 08/2015 indicated the following: This facility considers hand hygiene the primary means to prevent the spread of infection. The policy read, "Hand hygiene must be performed after touching bodily fluids and contaminated items." Expectations were to perform hand hygiene when indicated to avoid transfer of microorganisms to other residents, personnel, equipment and the environment. The following list are of some situations listed in the facility policy that require hand washing or hand sanitization: e. before and after handling an invasive device such as urinary catheter, i. after contact with resident skin, and j. after contact with blood or bodily fluids. A continuous observation was made on 03/05/24 starting at 11:24 AM of incontinence care being provided to Resident #57 by Nurse Aides (NA) #3 and NA #4. Resident #57 rang his call light at 11:24 AM which was answered by NA #4 and requested to be changed. NA #4 sanitized her hands and donned gloves then began to provide incontinence care to the Resident who was incontinent of feces. The NA turned the Resident to his right side and cleansed the feces. The NA had to leave the room to retrieve a turn sheet from the linen cart and removed her gloves and sanitized her hands before she left the Resident's room. When NA #4 returned to Resident #57's room, NA #3 followed behind her to assist NA #4 in completing the task. NA #3 donned gloves and assisted with turning Resident #57. When the Resident was turned onto his back NA #3 retrieved a premoisten wipe from NA #4 and proceeded to wipe feces from the Resident's	F 880	Criteria 2 On or before 3/29/24, DON or designee audited all Certified Nursing Assistants (CNA□s) for competency on appropriate infection control practices for glove usage, appropriate management of soiled linen, and handwashing during resident care. Any insufficient activity was corrected during the audit. Criteria 3 On 3/28/24, DON or designee completed education for all CNA□s and licensed nurses on the requirement to wash hands with soap and water or sanitize hands with an alcohol-based hand rub containing at least 62% alcohol when moving between residents to provide care. Education also included handwashing before and after glove use and disposal of gloves before exiting a resident□s room. In addition, CNA□s and licensed nurses were educated on the requirement for use of disposable bags for soiled materials. Education included the requirement to place soiled materials in the bag after use, close bag when incontinent care is completed, and dispose of bag in the appropriate receptacle. Newly hired licensed nurses and CNA□s will be educated upon hire and prior to accepting a resident assignment. Criteria 4 DON or designee will complete 5 observations of incontinent care per week	

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F 880	Continued From page 69 thigh then dropped the used wipe on the floor. NA #3 retrieved another wipe and cleansed Resident #57's indwelling urinary catheter near the meatus (a passage or opening leading to the interior of the body) then dropped the used wipe on the floor. The two NAs turned the Resident and positioned him on his back then NA #3 removed the dirty bed linens and dropped it directly onto the floor next to the used wipes. When the incontinent care was completed NA #4 removed her gloves and performed hand hygiene. NA #3, who was still wearing her gloves, picked up the wipes off the floor and put them in the trash can and removed the bag from the trash can then picked the dirty linen off the floor and put it in a separate plastic bag. Without removing her gloves NA #3 opened the door with her gloved hand and proceeded to carry the two bags into the hall. NA #3 while still wearing the same gloves which she had used to provide incontinent care lifted the lids to the soiled linen and trash cart and placed the bags into the linen and trash compartment of the cart. NA #3 proceeded to walk to the shower room where a resident was sitting in the hall, the resident was observed speaking to NA #3 and the NA opened the shower room door and retrieved a cell phone and handed it to him. The resident was observed speaking again to NA #3 and the NA replied, "My hands are dirty and I can't get to my phone," and while still wearing the same gloves she wore while providing incontinent care, the NA pushed the linen/trash cart up the hall, opened the door to the soiled utility room, by touching the door handle while still wearing the gloves she wore while providing incontinent care where she put the dirty linen bag into the soiled linen bin. Without removing the gloves NA #3 had used when providing incontinent care, she opened the	F 880	x 8 weeks to ensure that the appropriate infection control practices are utilized. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until substantial compliance is achieved and agreed upon by the QAPI committee. The Director of Nursing (DON) is responsible for this plan of correction. Criteria 5 Date of compliance is 3/30/24.	

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door by touching the door handle, pushed the trash cart down the service hall, opened the back door by touching the door handle, she then proceeded to push the trash cart to the dumpster and threw the trash bag into the dumpster then removed her gloves and threw them into the dumpster. Without being observed washing her hands the NA returned to the hall where she raised the fabric covering to the clean linen cart and removed two plastic bags and put them in the trash and linen cart. NA #3 then opened the shower room door and used hand sanitizer on her hands. The observation concluded at 12:00 PM on 03/05/24 when the NA was observed to have put hand sanitizer on her hands.

An interview conducted with Nurse Aide #3 on 03/05/24 at 12:00 PM. The NA explained that the facility held inservices on infection control and handwashing all the time. The NA stated the Assistant Director of Nursing (ADON) was forever telling her not to wear her gloves in the hall. The NA explained when she was providing care for Resident #57, she had put dirty wipes and linen on the floor instead of bags as she was taught because she was in a hurry, needed to get the task done, and continue her other duties on the hall. The NA stated she should have removed her gloves after performing the incontinence care and she remarked before she left the Resident's room, she should have removed the gloves and washed her hands. NA #3 realized she had not removed her gloves and washed/sanitized her hands since she left Resident #57's room and again, the NA stated she was in a hurry and needed to get the job done.

On 03/07/24 at 11:02 AM an interview was conducted with the Infection Preventionist (IP).

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F 880	Continued From page 71 The IP explained that she held a Skills Checklist once a year where they review the nurse aide's performance on several different care tasks which included hand hygiene. The IP continued to explain that NA #3 should have removed her glove over the hand she held the bags in when she left Resident #57's room and put the bags in the appropriate bin then washed her hands before she contaminated every surface she touched while wearing her gloves in the hall. The IP stated NA #3 was frequently counseled on wearing her gloves in the hall and her last handwashing review was on 01/06/24 and it looked like she needed more training. During an interview with the Director of Nursing (DON) on 03/08/24 at 9:07 AM the DON explained that she was already aware of the infection control issue with Nurse Aide #3 and stated the NA had handwashing reviews all the time. She stated NA #3 needed one on one education in handwashing.	F 880		