STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	C 04/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON STREET LINCOLNTON, NC 28092

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E 000	Initial Comments An unannounced recertification, complaint investigation, and follow up survey was conducted 04/08/24 through 04/13/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# Q7FU11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint was conducted on 04/08/24 through 04/11/24. Additional information on 04/13/24. Therefore, the exit date was changed to 04/13/24. The following intakes were investigated NC00215477, NC00215341, NC00211351, NC00209004, NC00208892, NC00207346, NC00206770, NC00206845, NC00206550, NC0020350, and NC199840. Event ID #Q7FU11. 6 of the 23 allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		5/14/24

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

Electronically Signed | 05/10/2024

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested for 1 of 3 residents reviewed for dignity (Resident #80). Resident #80 stated it made her upset to sit in a soiled brief and made her "feel like a third-class citizen" and she paid her bill like everyone else. The Findings included: Resident #80 was admitted to the facility on 07/05/22 with diagnoses of diabetes mellitus and	F 550	F550 □ Resident Rights/Exercise of Rights 1 On 4/8/2024, resident #80 was provided with incontinent care by the Unit Manager and Assistant Director of Nursing upon notification of the residents need. On 4/8/2024, the Certified Nursing Assistant # 1 was verbally re-educated by the Unit Manager on ensuring care and services are provided upon resident request. 2 On 4/15/2024, the Director	

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F 550	Continued From page 2 hypertension. The quarterly Minimum Data Set (MDS) assessment dated 01/31/24 revealed that Resident #80 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment reference period. An observation conducted on 04/08/24 at 10:30 AM revealed Resident #80 yelled into the hall and notified NA #1 she had a soiled brief. NA #1 was observed entering the room. Resident #80 was interviewed in her room on 04/08/24 at 10:45 AM. During the interview she stated she had been sitting in a soiled brief since 9:30 AM and knew this because she had been looking at the clock on the wall. She stated she had told NA #1 that she was sitting in a soiled brief and NA #1 acknowledged her and left the room. She stated she was still sitting in bowel movement and needed to be changed. During the interview Resident #80 stated, "It makes me feel like a third-class citizen, I pay my bill like everyone else". She went on to say it made her upset having to sit in a soiled brief filled with bowel movement. On 04/08/24 at 10:50 AM the surveyor told Unit Manager #1 that Resident #80 was sitting in a soiled brief. An observation was conducted at 10:57 AM of Unit Manager #1 and Assistant Director of Nursing (ADON) providing incontinence care to Resident #80. Resident #80's top sheet, bed pad and fitted sheet were observed to be soiled with feces. Resident #80 was observed to have feces extending down onto	F 550	Nursing/designee interviewed all residents and or responsible parties to ensure they were receiving incontinent care upon request. There were no other residents identified as not having incontinent care provided upon request. By 4/19/2024, the Director of Nursing, Staff Development Coordinator and Unit Managers re-educated 100% of the Licensed Nurses and Certified Nursing Assistants on ensuring that a resident receives incontinent care upon request. Should the Nursing Assistant be unable to provide incontinent care as requested they are to ask for assistance from another nursing assistant and/or nurse. New hires will be educated by the Staff Development Coordinator during General Orientation on ensuring residents receive incontinent care upon request and should they be unable to provide care as requested they are to ask for assistance from another nursing assistant and/or nurse. 3 Starting 4/22/2024, the Director of Nursing, unit managers and licensed nurses will perform daily audits to ensure the residents are provided with incontinent care upon request 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks for a period of 3 months. 4 The resident rights audits will be brought by the Director of Nursing/designee to the Quality Assurance and Assessment/Quality Assessment and Performance Improvement meeting monthly. The	

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F 550	Continued From page 3 the thighs and covering her urinary catheter. A complete bed change was observed after the nurses provided incontinence care to Resident #80. On 04/08/24 at 9:49 AM an interview was conducted with Nurse Aide (NA)#1. During the interview she stated Resident #80 had told her she needed to be changed however she had already started running water down the hall for another resident's bed bath. The interview revealed she had planned on completing the bed bath prior to changing Resident #80. NA #1 stated she did not know Resident #80 had been sitting in a soiled brief since 9:30 AM. On 04/11/24 at 12:21 PM an interview was conducted with Unit Manager #1. Unit Manager #1 stated once you see a call light on you should provide the care or let another staff member know so the care was provided. Unit Manager #1 stated she had to complete an entire bed change for Resident #80 due to incontinence and that was not common in the facility. She stated typically the Nurse Aides were good about providing care. She stated no resident should feel upset, like a third-class citizen or have to sit in bowel movement. On 04/11/23 at 3:24 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she did assist Resident #80 with incontinence care and had to complete a bed change due to the incontinence. The ADON stated Nurse Aides should be providing care upon resident request. The interview revealed no resident should feel upset or have to ask twice to be changed while sitting in a brief with bowel movement.	F 550	Quality Assurance and Assessment/Quality Assessment and Performance Improvement committee will review the audits and determine if further recommendations are needed to obtain compliance for incontinent care being provided upon request for a minimum of 3 months or until substantial compliance has been achieved. 5 Completion Date 5/14/2024	

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F 550	Continued From page 4 On 04/09/24 at 8:55 AM an interview was conducted with the Director of Nursing (DON). She stated NA #1 should have provided care when the resident asked. The DON stated Resident #80 should never feel like a third-class citizen or upset because staff would not change her brief.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		5/14/24

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F 580	Continued From page 5 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident, Infusion Center Nurse, Nurse Practitioner, Medical Director, and staff interviews the facility failed to notify the physician of a facility-initiated discharge for 1 of 3 residents (Resident #1) reviewed for notification. On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Findings included: Resident #1 was admitted into the facility on 08/26/23 with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness.	F 580	F580 Notify of Changes 1 On 8/30/2023, the physician for Resident #1, was notified of the resident not being allowed to return to the center after a therapeutic leave outside of the center. On 4/11/2024, the Director of Nursing was re-educated by the Regional Clinical Director on notification to the physician for any facility-initiated discharge related to a resident who has gone on a therapeutic leave, physician appointment or leave of absence for any resident who would not be allowed to return to the center after the appointment. On 4/11/2024, the Vice President of Operations re-educated the Nursing	

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F 580	Continued From page 6 Review of Resident #1's admission Minimum Data Set (MDS) dated 8/28/23 revealed the resident was alert and oriented. The MDS further revealed Resident #1 had a tracheostomy. Interview conducted with the Respiratory Therapist (RT) revealed on 04/11/24 at 11:05 AM revealed Resident #1 was assessed on 08/27/23. She indicated he had a cuffed tracheostomy and recommended it be changed to an uncuffed tracheostomy due to nursing staff not being familiar with caring for a resident with a cuffed tracheostomy with a different cannula. The RT further revealed he was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated Resident #1 was not in distress and could have waited to have his trach change when supplies were obtained. Review of progress note completed by Nurse #1 dated 8/28/23 revealed Resident #1 was sent to the Emergency Room (ED). A phone interview conducted with Resident #1 on 04/11/24 at 6:10 PM revealed on 08/28/23 he was advised and aware he was going to an infusion appointment. Resident #1 further revealed while he was waiting on the transporter at the front of the facility a staff member (unable to recall specific staff member) dropped a bag in his lap with all his belongings and reported he was going to the Emergency Department (ED) after his appointment with no other information. Resident #1 further revealed he contacted a family member to pick him up and take him home from his infusion appointment because he had nowhere else to go.	F 580	Home Administrator, Director of Nursing and Admissions Director on the centers policy allowing residents to return to the center from a physician appointment, therapeutic leave or leave of absence. 2 On 4/16/2024, the Director of Nursing and Unit Managers audited discharged residents for the past 6 months to ensure physicians were notified of any resident who was not allowed to return following a physician appointment, therapeutic leave or leave of absence. No other residents were noted to be affected. By 4/21/2024, Licensed Nurses, Unit Managers, and Nursing Supervisors were re-educated by the Director of Nursing on ensuring if a resident goes to a physician appointment, leave of absence or therapeutic leave they will be allowed to return to the center. New staff will be educated on the process of notification to the resident□s physician for a facility initiated discharge and allowing residents to return to the center from a physician appointment, therapeutic leave, or leave of absence. 3 Starting 4/22/2024, The Director of Nursing and/or Unit Managers will audit resident records daily during the morning clinical meeting to ensure the physician is notified on any resident leaving the center for a therapeutic leave, physician appointment or leave of absence. This audit will be conducted daily during the morning clinical meeting for twelve weeks. 4 The notification to physician audits will be brought by the Director of	

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F 580	Continued From page 7 A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the Infusion Center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. She indicated she was contacted the Admissions Director because Resident #1 did not have any orders and the Infusion Center did not feel comfortable sending the resident to the ED. It was reported to the Infusion Center Nurse #1 from the facility Admissions Director the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was indicated Infusion Center Nurse #1 indicated Resident #1 had a bag packed with his belongings. A phone interview with the prior Admissions Director on 04/09/24 at 6:00 PM revealed she recalled having a conversation with the infusion care center staff and it was an "ugly conversation" but could not recall anything that was discussed. It was further revealed the Admissions Director could not recall any part of Resident #1 being discharged on 08/28/23. Interview conducted with the Director of Nursing (DON) on 04/10/24 at 3:35 PM revealed the Respiratory Therapist (RT) assessed Resident #1 on 08/27/24 and recommended Resident #1 have his tracheostomy changed from a cuffed to an uncuffed tracheostomy. The DON further revealed Resident #1 had an appointment to the infusion center on 08/28/24 and she decided for the Resident #1 to have his tracheostomy changed at the Emergency Department (ED) afterwards since the facility did not have the supplies to do so at the facility. The DON stated she could not recall why she did not notify the	F 580	Nursing/designee to the Quality Assurance and Assessment/Quality Assessment and Performance Improvement meeting monthly. The Quality Assurance and Assessment/Quality Assessment and Performance Improvement committee will review the audits and determine if further recommendations are needed to ensure physicians are notified on residents who require an offsite physician appointment, therapeutic leave or leave of absence for minimum of 3 months or when substantial compliance has been achieved.	

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F 580	Continued From page 8 Nurse Practitioner (NP) or the Medical Director (MD) to obtain orders for ED transfer and tracheostomy change. The DON stated she had planned for Resident #1 to come back to the facility in the evening of 08/28/23 and was not aware the resident had taken his belongings with him. The DON stated she was not aware the facility Admissions Director had reported to the infusion center that Resident #1could not return to the facility. Interview with the Nurse Practitioner (NP) on 04/11/24 at 10:35 AM revealed she had not assessed Resident #1 during his stay in the facility and did not recall any conversation with the facility that Resident #1 was being sent out to have their trach changed. The NP indicated she could not recall who notified her that Resident #1 had left against medical advice (AMA) but someone from the facility had reported it to her. Interview with the Medical Director (MD) on 04/10/24 at 4:55 PM revealed he had not assessed Resident #1 during his stay in the facility. The MD further revealed he was not notified that the resident had been sent out to the emergency room to have his tracheostomy changed. The MD further revealed he was unable to recall who notified the MD Resident #1 had left AMA and was not returning to the facility on 08/30/23.	F 580		
F 624 SS=G	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure	F 624		5/14/24

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F 624	Continued From page 9 safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and resident, Resident Representative,staff, Infusion Center staff, Nurse Practitioner, and Medical Director interviews the facility failed to provide a safe and orderly discharge for 1 of 3 residents (Resident #1). On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Resident #1 was not provided with discharge paperwork or discharge instructions and did not understand what was happening. The discharge location was not verified, home health services were not ordered at the time of discharge, and the resident was not followed up with to ensure his needs were met. This resulted in Resident #1 feeling like he was being thrown out, abandoned, and was mad. Findings included: Review of the hospital discharge summary dated 08/26/23 revealed Resident #1 was admitted to the hospital on 08/07/23 due to Resident #1 having generalized body weakness and the family had also taken him to the hospital for placement. Resident #1 was admitted with throat cancer and a tracheostomy and was diagnosed with adult failure to thrive and increased general weakness. Resident #1 was discharged from the hospital on 08/26/23 and referred to the facility for skilled services.	F 624	F624 Preparation for Safe/Orderly Transfer/Discharge 1 On 8/28/2023, Resident #1 was discharged from the center. On 4/11/2024, the Vice President of Operations re-educated the Nursing Home Administrator, Director of Nursing and Admissions Director on the centers policy residents to return to the center from a physician appointment, therapeutic leave or leave of absence. On 4/17/2024, the Director of Nursing and social service director were re-educated by the Regional Clinical Director on ensuring the resident and/or responsible party has received communication on the purpose of the appointment, should the resident and/or responsible party choose to discharge from the appointment all discharge paperwork and instructions have been arranged prior to leaving the center. 2 On 4/15/2024, an audit was completed by the Director of Nursing on current residents to ensure any scheduled appointments would have transportation arranged for the resident to return to the center after the appointment, resident would be allowed to return to the center and ensure the physician, resident and/or responsible party are notified of the reason for the appointment/therapeutic	

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F 624	Continued From page 10 Resident #1 was admitted to the facility on 08/26/23 with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness. Review of Resident #1's admission Minimum Data Set (MDS) dated 8/28/23 revealed the resident was alert and oriented. The MDS further revealed Resident #1 had a tracheostomy. A phone interview conducted with the Respiratory Therapist (RT) revealed on 04/11/24 at 11:05 AM revealed Resident #1 was assessed on 08/27/23 and revealed Resident #1 had a cuffed tracheostomy and recommended it be changed to an uncuffed tracheostomy because uncuffed tubes allow airway clearance but provide no protection from aspiration and cuffed tracheostomy tubes allow secretion clearance and offer some protection from aspiration. The RT revealed nursing staff was not familiar with caring for a resident with a cuff tracheostomy. The RT further revealed he was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated he did not write physician orders and that the Nurse Practitioner (NP) or Medical Director (MD) would have to be notified to obtain the order to change the tracheostomy type. The RT indicated Resident #1 was not in distress and could have waited to have his trach changed when supplies were obtained but the Director of Nursing (DON) made the RT aware the decision was made to send Resident #1 to the ED after the infusion appointment on 08/28/23. Review of a progress note completed by Nurse #1 dated 8/28/23 revealed Resident #1 was at the Emergency Room (ED).	F 624	leave or leave of absence. No other residents were identified as needing further arrangements made to facilitate the discharge process On 4/17/2024, the Social Services Director, Rehabilitation Director, Activities Director, Maintenance Director, Business Office Manager, Human Resource Manager, Receptionist Staff, Minimum Data Set Director, Unit Managers, Licensed Nurses and Business Office Staff were re-educated by the Regional Clinical Director and/or Vice President of Operations on the residents right to return to the center after a physician appointment, therapeutic leave or leave of absence. On 5/2/2024, the Unit Managers, Minimum Data Set Coordinator, Business Office Manager, Staff Development Coordinator, Infection Prevention Control Officer, Activities Director, Medical Records, Rehabilitation Program Manager, Admissions Manager and Director or Nursing educated current residents or their responsible party ensuring they are aware of the residents right to return to the center after an appointment, therapeutic leave or leave of absence on future therapeutic leaves. 3 Starting 4/22/2024, an audit will be completed daily during the morning clinical meeting 3 times a week for twelve weeks on therapeutic leaves and/or discharges was completed to ensure residents on therapeutic leave, going to a physician appointment or on leave of absence have been permitted to return to the center and ensure the physician, resident and/or responsible party are	

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F 624	Continued From page 11 A phone interview conducted with Resident #1 on 04/11/24 at 6:10 PM revealed on 08/28/23 he was advised and aware he was going to an infusion appointment. Resident #1 further revealed while he was waiting on the transporter at the front of the facility and a staff member (unable to recall specific staff member) dropped a bag in his lap with all his belongings and reported he was going to the Emergency Department (ED) after his appointment with no other information. Resident #1 indicated once he arrived at the infusion appointment with his bag the infusion staff nurse revealed to Resident #1 they had received a message from the facility to send the resident to the ED after his appointment. The infusion staff nurse explained to him that they could not send him to the ED because Resident #1 did not have an order. Resident #1 stated at this time he felt he was being discharged without knowledge and he felt like he was being thrown out, abandoned and was mad. Resident #1 revealed the Infusion Nurse contacted the facility Admissions Director and was told Resident #1 could not return to the facility. Resident #1 further revealed he contacted a family member to pick him up and take him home from his infusion appointment because he had nowhere else to go. Resident #1 indicated the facility had his personal phone number and did not attempt to contact his Resident Representative (RR) until 08/30/23 after Resident #1's primary care office reached out to the facility. Resident #1 stated the facility did not provide any discharge information, discharge services, medicines, or supplies once he left the facility. Resident #1 indicated he was able to perform self trach care and had medications and tube feeding formula when he returned home.	F 624	notified of the reason for the appointment/therapeutic leave or leave of absence. Should the resident and/or responsible party determine to be discharged from the appointment to home all discharge needs will be arranged prior to the resident leaving the center. 4 The therapeutic leave and/or discharge audits will be brought by the Director of Nursing/designee to the Quality Assurance and Assessment/Quality Assessment and Performance Improvement meeting monthly. The Quality Assurance and Assessment/Quality Assessment and Performance Improvement committee will review the therapeutic leave and/or discharge audits and determine if further recommendations are needed for minimum of 3 months or when substantial compliance has been achieved.	

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A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director because Resident #1 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was observed by Infusion Center Nurse #1 that Resident #1 had a bag packed with his belongings and Resident #1 was observed to be frustrated and was confused on being discharged without notice. Infusion Center Nurse #1 stated Resident #1 contacted his RR to pick him up and Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him.

A phone interview with Infusion Center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center upset, with his belongings with him, and reported he believed was being discharged without notice. It was further revealed Infusion Center Nurse #1 contacted the facility and it was reported Resident #1 could not return to the facility and had to be sent to the ED after his appointment. Infusion Center Nurse #2 indicated the infusion center staff did not feel comfortable sending the resident to the ED without orders and the resident did not observe to be in medical distress. Infusion Center Nurse #2 stated Resident #1 called his RR to come get him from the infusion center. Infusion Center Nurse #2 stated she felt like the facility had "dumped" Resident #1 and she was very

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upset for Resident #1.

A phone interview with the prior Admissions Director on 04/09/24 at 6:00 PM revealed she recalled having a conversation with the infusion care center staff and it was an "ugly conversation" but could not recall anything that was discussed. It was further revealed the Admissions Director could not recall any part of what had occurred with Resident #1 from 08/28/23 through 08/31/23.

A phone interview conducted with Resident #1's Resident Representative (RR) on 04/11/24 at 10:15 AM revealed Resident #1 was admitted to the facility after his hospital stay due to needing more care than the family could assist with. It was further revealed on 08/28/23 the RR was not notified prior that Resident #1 was being sent out for an infusion appointment but was contacted by the facility Admissions Director that Resident #1 was on his way to an infusion appointment and would have to be sent to the ED because the facility could not care for the resident's tracheostomy. The RR stated the facility Admissions Director revealed Resident #1 could not return to the facility. The RR revealed she arrived at Resident #1's infusion appointment and the Infusion Center Nurse #1 had contacted the facility as well and had reiterated the same information that the resident could not return to the facility. It was further revealed Resident #1 had a bag with his belongings and was very mad about being discharged without notice. The RR further revealed she took Resident #1 home because she felt like the facility had dumped him and she had no other choice.

An interview conducted with the Assistant Director of Nursing (ADON) on 04/10/24 at 3:05 PM

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revealed she assisted in getting Resident #1 ready for his appointment on 8/28/23 and had given him a folder that had information for his appointment. The ADON indicated she did not recall the resident having a bag packed or having any concerns. The ADON stated Resident #1 was admitted with a cuffed trach that the facility did not have supplies for, and staff did not have the training to care for. The ADON stated she believed Resident #1 was admitted by accident because the facility normally would not accept a resident with a cuffed trach. The ADON indicated she had thought Resident #1 had been sent to the ED to have Resident #1's trach changed and was not aware until Resident #1's primary care office reached out on 08/30/23 that the resident was at home. The ADON revealed then she reached out to Resident #1's RR and it was revealed Resident #1 did not have the preferred liquid form of metformin and insulin. The ADON indicated she contacted the on-call provider on 08/30/24 and obtained orders for Resident #1's medications. The ADON was not aware that no staff from the facility had reached out to Resident #1 and was not sure why he did not return to the facility.

An interview conducted with the facility Social Worker (SW) on 04/11/24 at 9:25 AM revealed he did not become involved with Resident #1 until 08/30/23 when Resident #1's primary care office contacted the facility to let them know Resident #1 was at home. The SW further revealed at that time he completed an Adult Protective Services (APS) report to make sure Resident #1 was safe and completed referrals for in home health but did not follow up to see if Resident #1 had been accepted for services.

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An interview conducted with the Director of Nursing (DON) on 04/10/24 at 3:35 PM revealed the Respiratory Therapist (RT) assessed Resident #1 on 08/27/24 and recommended Resident #1 have his tracheostomy changed from a cuffed to an uncuffed trach. The DON further revealed Resident #1 had an appointment at the infusion center on 08/28/23 and she decided for the Resident #1 to have his tracheostomy changed at the Emergency Department (ED) afterwards since the facility did not have the supplies to do so at the facility. The DON stated she could not recall why she did not notify the Nurse Practitioner (NP) or the Medical Director (MD) to obtain orders to do so. The DON stated she had planned for Resident #1 to come back to the facility in the evening of 08/28/23 and was not aware the resident had taken his belongings with him. The DON revealed nursing staff failed to follow up with the whereabouts of Resident #1 during second and third shift on 08/28/23 with the thought Resident #1 was still at the hospital, and no one realized he wasn't there on 8/29/23 either. The DON indicated on 08/30/23 it was found out that Resident #1 went home from his appointment on 08/28/23 when the facility received a phone call from Resident #1's primary care office. The DON indicated an APS report was completed, referrals from in home health were completed, and orders were obtained for Resident #1 to receive medicine. The DON stated she was not aware the prior Admissions Director told Resident #1 that he could not return to the facility.

An interview with the Nurse Practitioner (NP) on 04/11/24 at 10:35 AM revealed she had not assessed Resident #1 during his stay in the facility and did not recall any conversation with

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F 624	Continued From page 16 the facility that Resident #1 was being sent out to have their trach changed. The NP indicated she could not recall who and on what date, but she was notified Resident #1 had left against medical advice (AMA). A phone Interview with the Medical Director (MD) on 04/10/24 at 4:55 PM revealed he had not assessed Resident #1 during his stay in the facility. The MD further revealed he could not recall who had reported that Resident #1 had left against medical advice (AMA) on 08/30/23. Interview with the Administrator on 04/11/23 at 4:00 PM revealed he was made aware by the DON on 8/28/23 that Resident #1 was being sent out to the infusion center on 8/28/23 and then heading to ED for trach change. The Administrator further revealed it was RT's recommendations and was not aware the RT could not write orders. The Administrator revealed he was unsure if Resident #1 had left with his belongings and was not aware of who was responsible for following up with Resident #1's whereabouts after he did not return from his appointment.	F 624		
F 626 SS=G	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the	F 626		5/14/24

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F 626	Continued From page 17 State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and resident, Resident Representative,staff, Infusion Center staff, Nurse Practitioner, and Medical Director interviews the facility failed to permit a resident to return to the facility from therapeutic leave for 1 of 3 residents (Resident #1). On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Resident #1 was not allowed to return to the facility following the appointment.	F 626	F 626 Permitting Residents to Return to Facility 1 On 8/28/2023, Resident #1 was discharged from the center. On 4/11/2024, the Vice President of Operations re-educated the Nursing Home Administrator, Director of Nursing and Admissions Director on the centers policy residents to return to the center from a physician appointment, therapeutic leave	

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F 626	Continued From page 18 This resulted in Resident #1 feeling like he was being thrown out, abandoned, and was mad. Findings included: Review of the hospital discharge summary dated 08/26/23 revealed Resident #1 was admitted to the hospital on 08/07/23 due to Resident #1 having generalized body weakness and the family had also taken him to the hospital for placement. Resident #1 was admitted with throat cancer and a tracheostomy and was diagnosed with adult failure to thrive and increased general weakness. Resident #1 was discharged from the hospital on 08/26/23 and referred to the facility for skilled services. Resident #1 was admitted to the facility on 08/26/23 with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness. Review of Resident #1's admission Minimum Data Set (MDS) dated 8/28/23 revealed the resident was alert and oriented. The MDS further revealed Resident #1 had a tracheostomy. A phone interview conducted with the Respiratory Therapist (RT) revealed on 04/11/24 at 11:05 AM that Resident #1 was assessed on 08/27/23 and revealed Resident #1 had a cuffed tracheostomy and recommended it be changed to an uncuffed tracheostomy because uncuffed tubes allow airway clearance but provide no protection from aspiration and cuffed tracheostomy tubes allow secretion clearance and offer some protection from aspiration. The RT revealed nursing staff was not familiar with caring for a resident with a cuff tracheostomy. The RT further revealed he	F 626	or leave of absence. On 4/17/2024, the Director of Nursing and social service director were re-educated by the Regional Clinical Director on ensuring the resident and/or responsible party has received communication on the purpose of the appointment, should the resident and/or responsible party choose to discharge from the appointment all discharge paperwork and instructions have been arranged prior to leaving the center. 2 On 4/15/2024, an audit was completed by the Director of Nursing on current residents to ensure any scheduled appointments would have transportation arranged for the resident to return to the center after the appointment, resident would be allowed to return to the center and ensure the physician, resident and/or responsible party are notified of the reason for the appointment/therapeutic leave or leave of absence. No other residents were identified as needing further arrangements made to facilitate the discharge process On 4/17/2024, the Social Services Director, Rehabilitation Director, Activities Director, Maintenance Director, Business Office Manager, Human Resource Manager, Receptionist Staff, Minimum Data Set Director, Unit Managers, Licensed Nurses and Business Office Staff were re-educated by the Regional Clinical Director and/or Vice President of Operations on the residents right to return to the center after a physician appointment, therapeutic leave or leave of absence. On 5/2/2024, the Unit Managers, Minimum Data Set	

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F 626	Continued From page 19 was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated he did not write physician orders and that the Nurse Practitioner (NP) or Medical Director (MD) would have to be notified to obtain the order to change the tracheostomy type. The RT indicated Resident #1 was not in distress and could have waited to have his trach changed when supplies were obtained but the Director of Nursing (DON) made the RT aware the decision was made to send Resident #1 to the ED after the infusion appointment on 08/28/23. A phone interview conducted with Resident #1 on 04/11/24 at 6:10 PM revealed on 08/28/23 he was advised and aware he was going to an infusion appointment. Resident #1 further revealed while he was waiting on the transporter at the front of the facility a facility staff member (unable to recall specific staff member) dropped a bag in his lap with all his belongings and reported he was going to the Emergency Department (ED) after his appointment with no other information. Resident #1 indicated once he arrived at the infusion appointment with his bag the infusion staff nurse revealed to Resident #1 they had received a message from the facility to send the resident to the ED after his appointment. The infusion staff nurse explained to him that they could not send him to the ED because Resident #1 did not have an order. Resident #1 stated at this time he felt he was being discharged without knowledge and he felt like he was being thrown out, abandoned and was mad. Resident #1 revealed the Infusion Nurse contacted the facility Admissions Director and was told Resident #1 could not return to the facility. Resident #1 further revealed he contacted a family member to pick him up and take him home from his infusion appointment because he	F 626	Coordinator, Business Office Manager, Staff Development Coordinator, Infection Prevention Control Officer, Activities Director, Medical Records, Rehabilitation Program Manager, Admissions Manager and Director or Nursing educated current residents or their responsible party ensuring they are aware of the residents right to return to the center after an appointment, therapeutic leave or leave of absence on future therapeutic leaves. 3 Starting 4/22/2024, an audit will be completed daily during the morning clinical meeting 3 times a week for twelve weeks on therapeutic leaves and/or discharges was completed to ensure residents on therapeutic leave, going to a physician appointment or on leave of absence have been permitted to return to the center and ensure the physician, resident and/or responsible party are notified of the reason for the appointment/therapeutic leave or leave of absence. Should the resident and/or responsible party determine to be discharged from the appointment to home all discharge needs will be arranged prior to the resident leaving the center. 4 The therapeutic leave and/or discharge audits will be brought by the Director of Nursing/designee to the Quality Assurance and Assessment/Quality Assessment and Performance Improvement meeting monthly. The Quality Assurance and Assessment/Quality Assessment and Performance Improvement committee will	

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had no other place to go. Resident #1 indicated he was able to care for himself and contact 911 in case of an emergency.

A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion appointment but did not explain what Resident #1 was being sent to the ED for. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director directly and it was explained by the Admissions Director Resident #1 needed a trach change. The Infusion Center Nurse #1explained to the Admissions Director Resident #1 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director that the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement and the resident could not return to the facility. It was observed by Infusion Center Nurse #1 that Resident #1 had a bag packed with his belongings and Resident #1 was observed to be frustrated and confused on not being able to return to the facility.

A phone interview with Infusion Center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center upset, with his belongings with him, and reported he believed was being discharged without notice. It was further revealed Infusion Center Nurse #1 contacted the facility and it was reported Resident #1 could not return to the facility and had to be sent to the ED after his appointment. Infusion Center Nurse #2 indicated the infusion center staff did not feel comfortable sending the resident

review the therapeutic leave and/or discharge audits and determine if further

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to the ED without orders and the resident did not observe to be in medical distress.

A phone interview with the prior Admissions Director on 04/09/24 at 6:00 PM revealed she recalled having a conversation with the infusion care center staff and it was an "ugly conversation" but could not recall anything that was discussed. It was further revealed the Admissions Director could not recall any part of what had occurred with Resident #1 from 08/28/23 through 08/31/23.

A phone interview conducted with Resident #1's Resident Representative (RR) on 04/11/24 at 10:15 AM revealed Resident #1 was admitted to the facility after his hospital stay due to needing more care than the family could assist with. It was further revealed on 08/28/23 the RR was contacted by the facility Admissions Director that Resident #1 was on his way to an infusion appointment and would have to be sent to the ED because the facility could not care for the resident's tracheostomy. The RR stated the facility Admissions Director revealed Resident #1 could not return to the facility. The RR revealed she arrived at Resident #1's infusion appointment and the Infusion Center Nurse #1 had contacted the facility as well and had reiterated the same information that the resident could not return to the facility. It was further revealed Resident #1 had a bag with his belongings and was very mad about being discharged without notice. The RR further revealed she took Resident #1 home because she felt like the facility had dumped him and she had no other choice.

An interview conducted with the Assistant Director of Nursing (ADON) on 04/10/24 at 3:05 PM revealed she assisted in getting Resident #1

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ready for his appointment on 8/28/23 and had given him a folder that had information for his appointment. The ADON indicated she did not recall the resident having a bag packed or having any concerns. The ADON stated Resident #1 was admitted with a cuffed trach that the facility did not have supplies for, and staff did not have the training to care for. The ADON stated she believed Resident #1 was admitted by accident because the facility normally would not accept a resident with a cuffed trach. The ADON indicated she had thought Resident #1 had been sent to the ED to have Resident #1's trach changed and was not aware until Resident #1's primary care office reached out on 08/30/23 that the resident was home. The ADON was not aware that no staff from the facility had reached out to Resident #1 and was not sure why he did not return to the facility.

An interview conducted with the Director of Nursing (DON) on 04/10/24 at 3:35 PM revealed the Respiratory Therapist (RT) assessed Resident #1 on 08/27/24 and recommended Resident #1 have his tracheostomy changed from a cuffed to an uncuffed trach. The DON further revealed Resident #1 had an appointment at the infusion center on 08/28/23 and she decided for the Resident #1 to have his tracheostomy changed at the Emergency Department (ED) afterwards since the facility did not have the supplies to do so at the facility. The DON stated she could not recall why she did not notify the Nurse Practitioner (NP) or the Medical Director (MD) to obtain orders to do so. The DON stated she had planned for Resident #1 to come back to the facility in the evening of 08/28/23 and was not aware the resident had taken his belongings with him. The DON revealed nursing staff failed to

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F 626	Continued From page 23 follow up with the whereabouts of Resident #1 during second and third shift on 08/28/23 with the thought Resident #1 was still at the hospital, and no one realized he wasn't there on 8/29/23 either. The DON indicated on 08/30/23 it was found out that Resident #1 went home from his appointment on 08/28/23 when the facility received a phone call from Resident #1's primary care office. DON stated she was not aware the prior Admissions Director told Resident #1 that he could not return to the facility. An interview with the Nurse Practitioner (NP) on 04/11/24 at 10:35 AM revealed she had not assessed Resident #1 during his stay in the facility and was not notified Resident #1 had been assessed by the RT and required an order to be obtained to have the resident's trach changed. A phone Interview with the Medical Director (MD) on 04/10/24 at 4:55 PM revealed he had not assessed Resident #1 during his stay in the facility and was not notified Resident #1 had been assessed by the RT and required an order to be obtained to have the resident's trach changed. Interview with the Administrator on 04/11/23 at 4:00 PM revealed he was made aware by the DON on 8/28/23 that Resident #1 was being sent out to the infusion center on 8/28/23 and then heading to ED for trach change. The Administrator further revealed it was RT's recommendations and was not aware the RT could not write orders and the physicians had not been notified about Resident #1.	F 626		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		5/14/24

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F 644	Continued From page 24 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for resident with mental health diagnosis upon admission and residents with new mental health diagnoses for 2 of 3 residents (Resident #67 and #90) reviewed for PASRR. The findings include: 1. Review of Resident #67's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on 02/10/22. The resident had been diagnosed with anxiety disorder on 6/22/23, major depressive disorder on 6/22/23, post-traumatic stress disorder (PTSD) on 12/28/23, and mood (affective) disorder on	F 644	F 644 Coordination of PASARR and Assessments 1 On 4/15/2024, the PASARR for resident #67 and 90 was reviewed with a level II PASARR request by the social services director. On 4/15/2024, the social service director was re-educated by the Nursing Home Administrator on ensuring all level II PASARR□s are correctly applied for upon admission or with any new onset of behaviors. 2 By 4/22/2024, an audit on current resident PASARR□s was completed by the social services director ensuring all PASARR□s are correct, and any level II requests are completed. There were no	

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F 644	Continued From page 25 1/31/24. No PASRR level II had been completed per Resident # medical records. During an interview on 4/11/24 at 8:57 AM with the Social Worker (SW) revealed he had been employed as the facility SW over the past several years and since that time had been responsible for completing PASRR upon a resident admission if needed, when a change in condition or behavior had occurred, or when there had been a new diagnosis. He revealed he would review a resident's diagnosis and PASRR level once they were admitted and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition to determine if paperwork for a level II PASRR would need to be completed. The SW stated he had not been made aware of Resident #67 new mental health diagnosis of anxiety disorder, major depressive disorder, PTSD, and mood (affective) disorder and felt it could have been an oversight, however based on new diagnosis and the preadmission level I PASRR, paperwork for a PASRR level II should have been completed. During an interview on 4/11/24 at 5:35 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. He stated based on Resident #67 newly added diagnosis of anxiety disorder, major depressive disorder, PTSD, and mood (affective) disorder a PASRR level II should have been completed. 2. Review of Resident #90 medical record revealed the resident had a PASRR level I	F 644	other incomplete PASARR□s found during the audit. On 4/15/2024, the new social service director was educated on the importance of reviewing all PASARR□s upon admission, with any new onset behavior and ensuring they are correctly completed. New hires into the social services department will be educated on ensuring PASARR Level I and II are completed correctly. 3 Starting on 4/22/2024, the social services director/designee will audit PASARR□s 3 times a week for twelve weeks to ensure all residents have a appropriately completed PASARR to include a level II PASARR if indicated. 4 The PASARR audits will be brought by the Director of Nursing/designee to the Quality Assurance and Assessment/Quality Assessment and Performance Improvement meeting monthly. The Quality Assurance and Assessment/Quality Assessment and Performance Improvement committee will review the audits and determine if further recommendations are needed to obtain compliance for care and services being provided during mealtimes for minimum of 3 months or when substantial compliance has been achieved.	

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completed prior to her admission and was admitted to the facility on 3/08/24. The resident was diagnosed with major depressive disorder on 3/08/24 and unspecified mood disorder on 3/08/24 upon admission. No PASRR level II had been completed per Resident #90 medical records.

During an interview on 4/11/24 at 8:57 AM with the Social Worker (SW) revealed he had been employed as the facility SW and since that time had been responsible for completing PASRR upon a resident admission if needed, when a change in condition or behavior had occurred, or when there had been a new diagnosis. He revealed he would review a resident's diagnosis and PASRR level once they were admitted and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition to determine if paperwork for a level II PASRR would need to be completed. The SW stated Resident #90 admission diagnosis and level of PASRR had simply been overlooked, however based on Resident #90 admission diagnosis of major depressive disorder and unspecified mood disorder and the preadmission PASRR level I, paperwork for a PASRR level II should have been completed.

During an interview on 4/11/24 at 5:35 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. He stated based on Resident #90 admission diagnosis of major depressive disorder and unspecified mood disorder a PASRR level II should have been completed.

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F 677 SS=G	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 resident and staff interview the facility failed to provide incontinence care when requested for 2 of 3 residents reviewed for activities of daily living care (Resident #53 and Resident #80). Resident #53 was noted to have a new open area to the right buttocks when incontinence care was provided, and Resident #53 reported the area was sore. Findings included: 1. Resident #53 was admitted to the facility on 10/02/23 with diagnoses of hip fracture and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 02/07/24 revealed that Resident #53 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment reference period. Resident #53 was interviewed in her room on 04/08/24 at 9:49 AM. During the interview she stated she had been sitting in a soiled brief since after breakfast at 8:45 AM. She stated Nurse Aide (NA) #1 had answered her call light around 8:45 AM and stated she was picking up breakfast trays on the hall and could not provide incontinence	F 677	F 677 □ ADL Care Provided for Dependent Residents 1 On 4/8/2024, resident #80 was provided with incontinent care by the Unit Manager and Assistant Director of Nursing upon notification of the residents need. On 4/8/30324, resident # 53 was provided incontinent care by the NA #1 and the Unit Manager upon notification of the residents need. On 4/8/2024, the Certified Nursing Assistant # 1 was verbally re-educated by the Unit Manager on ensuring care and services are provided upon resident request. The Certified Nursing Assistant #1 no longer works at the center. 2 On 4/15/2024, the Director Nursing/designee interviewed all residents and or responsible parties to ensure they were receiving care upon request. There were no other residents identified as not having care and services provided upon request. By 4/19/2024, the Director of Nursing, Staff Development Coordinator and Unit Managers re-educated the nursing staff on ensuring that a resident receives care and services upon request. 3 Starting 4/22/2024, the Director of	5/14/24

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F 677	Continued From page 28 care but would return after trays were off the hall. Resident #53 stated NA #1 had not returned to the room and she was sitting in feces. She stated she knew NA #1 had a lot to do and she was not upset over having to wait. On 04/08/24 at 9:58 AM the surveyor told NA #1 that Resident #53 needed incontinence care. NA #1 stated she was passing out soap on the hall and that she knew the resident had been waiting for incontinence care but had not been back in the room. An observation was conducted on 04/08/24 at 10:18 AM of incontinence care for Resident #53 with NA #1 and Unit Manager #1. Resident #53 was noted to have bowel movement in her brief at the time of the observation. She was noted with redness on her bottom and stated the area was, "sore". The stool was not observed to be dried to the resident's skin. On 04/08/24 at 11:11 AM an interview was conducted with NA #1. During the interview she stated Resident #53 had turned her call light on around 8:30-8:45 AM and stated she needed to be changed. NA #1 stated she went into the room and turned the call light off because she could not provide incontinence care while meal trays were on the halls. She stated she was going to go back to Resident #53's room and provide care but she had forgotten. On 04/11/24 at 12:21 PM an interview was conducted with Unit Manager #1. During the interview she stated no staff member had ever told Nurse Aides that they could not provide incontinence care while meal trays were on the halls. She stated unless the Nurse Aides were	F 677	Nursing, unit managers and licensed nurses will perform daily audits 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 2 times a week for 4 weeks for a period of 3 months to ensure the residents are provided with care and services upon request. 4 The resident rights audits will be brought by the Director of Nursing/designee to the Quality Assurance and Assessment/Quality Assessment and Performance Improvement meeting monthly. The Quality Assurance and Assessment/Quality Assessment and Performance Improvement committee will review the audits and determine if further recommendations are needed to obtain compliance for care and services being provided upon request for a minimum of 3 months or until substantial compliance has been achieved. 5 Completion Date 5/14/2024	

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actively assisting someone with a meal, they should stop what they're doing and provide incontinence care. She stated Resident #53 had redness to her bottom when she was assisting NA #1 with incontinence care, and she notified the wound nurse.

On 04/08/24 at 5:15 PM a nursing progress note written by the Assistant Director of Nursing (ADON) revealed Resident #53 was noted with a new open area to the right buttocks which was caused by excoriation. "A new order for zinc oxide (a cream used to treat minor skin irritations) was applied and the ADON left a message for the wound Physician to see Resident #53".

A physician order dated 04/08/24 revealed Resident #53 received an order for zinc oxide to be applied to the residents buttocks every shift three times a day for a duration of 30 days.

On 04/11/24 at 3:24 PM an interview was conducted with the Assistant Director of Nursing (ADON). During the interview she stated she was the acting wound nurse in the facility. She stated she went in and assessed Resident #53 on 04/08/24. She stated she noted excoriation (scraped or abraded skin) on the resident's buttocks. The ADON stated she initiated Zinc Oxide for treatment of the area. She stated she felt the area was caused by the way the resident sat in the bed and not from sitting in a soiled brief because she had this issue prior while being in the facility.

A wound note written by the wound physician dated 04/09/24 revealed Resident #53 had a new wound care assessment completed. Resident #53 was noted to have a non-pressure wound of

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the right upper buttock measuring 1.4-centimeter (cm) length by 0.6 cm width by 0.1 cm depth. The duration of the wound was noted to be at least 2 days.

On 04/09/24 at 8:55 AM an interview was conducted with the Director of Nursing (DON). She stated NA #1 should have provided care when the resident asked. The interview revealed staff were able to provide care regardless of if meal trays were on the hall. The interview revealed she did not feel like having residents wait for incontinence care was an acceptable practice.

2. Resident #80 was admitted to the facility on 07/05/22 with diagnoses of diabetes mellitus and hypertension.

The quarterly Minimum Data Set (MDS) assessment dated 01/31/24 revealed that Resident #80 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment reference period.

An observation conducted on 04/08/24 at 10:30 AM revealed Resident #80 yelled into the hall and notified NA #1 she had a soiled brief. NA #1 was observed entering the room.

Resident #80 was interviewed in her room on 04/08/24 at 10:45 AM. During the interview she stated she had been sitting in a soiled brief since 9:30 AM and knew this because she had been looking at the clock on the wall. She stated she had told NA #1 that she was sitting in a soiled brief with bowel movement and NA #1

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acknowledged her and left the room. She stated she was still sitting in bowel movement and needed to be changed.

On 04/08/24 at 10:50 AM the surveyor told Unit Manager #1 that Resident #80 was sitting in a soiled brief.

An observation was conducted on 04/08/24 at 10:57 AM of Unit Manager #1 and Assistant Director of Nursing (ADON) providing incontinence care to Resident #80. Resident #80's top sheet, bed pad and fitted sheet were observed to be soiled with feces. Resident #80 was observed to have feces extending down onto the thighs and covering her urinary catheter. A complete bed change was observed after the nurses provided incontinence care to Resident #80.

On 04/08/24 at 9:49 AM an interview was conducted with NA #1. During the interview she stated Resident #80 had told her she needed to be changed however she had already started running water down the hall for another resident's bed bath. The interview revealed she had planned on completing the bed bath prior to changing Resident #80. NA #1 stated she did not know Resident #80 had been sitting in a soiled brief since 9:30 AM.

On 04/11/24 at 12:21 PM an interview was conducted with Unit Manager #1. Unit Manager #1 stated once you see a call light on you should provide the care or let another staff member know so the care was provided. Unit Manager #1 stated she had to complete an entire bed change for Resident #80 due to incontinence and that was not common in the facility. She stated

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F 677	Continued From page 32 typically the Nurse Aides were good about providing care. On 04/11/23 at 3:24 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she did assist Resident #80 with incontinence care and had to complete a bed change due to the incontinence. The ADON stated Nurse Aides should be providing care upon resident request. On 04/09/24 at 8:55 AM an interview was conducted with the Director of Nursing (DON). She stated NA #1 should have provided care when the residents asked. The interview revealed she did not feel like having residents wait for incontinence care was an acceptable practice.	F 677		
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	F 867		5/14/24

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systems to identify, collect, and use data and information from all departments, including but 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

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(iii) How the facility will monitor the effectiveness of its performance improvement activities to 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

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F 867	Continued From page 35 assurance committee reports to the facility's governing body, or designated person(s) 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 and resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place in the areas of dignity and respect (F550) and notification of change (F580). Additionally, the facility's QAA Committee failed to identify deficient practice for a discharge that occurred on 8/28/23 and implement corrective action to ensure compliance was sustained in the area of safe and orderly discharge (F624). These 3 deficiencies were cited on the complaint investigation survey of 2/15/24 and subsequently recited on the current recertification and complaint investigation survey of 4/13/24. The facility's continued failure during two surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag was cross referenced to:	F 867	F867 QAPI/QAA Improvement Activities 1 On 4/8/2024, resident #80 was provided with incontinent care by the Unit Manager and Assistant Director of Nursing upon notification of the residents need. On 8/28/2023, Resident #1 was discharged from the center. On 8/30/2023, the physician for Resident #1, was notified of the resident not being allowed to return to the center after a therapeutic leave outside of the center. On 4/11/2024, an ADHOC Quality Assessment and Performance Improvement/Quality Assessment and Assurance was conducted by the Vice President of Operations. 2 On 4/8/2024, the Certified Nursing Assistant # 1 was verbally re-educated by the Unit Manager on ensuring care and services are provided upon resident request. The Certified Nursing Assistant #1 no longer works at the center. On	

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F 867	Continued From page 36 F 550: Based on record review and resident and staff interviews the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested for 1 of 3 residents reviewed for dignity (Resident #80). Resident #80 stated it made her upset to sit in a soiled brief and made her "feel like a third-class citizen" and she paid her bill like everyone else. During the complaint investigation survey of 02/15/24 the facility failed to treat a resident in a dignified manner when a Nurse Aide (NA) was rough and pushing on her during a transfer. This made the resident feel "unsafe" during the transfer and she stated this was a dignity issue. Additionally, the facility failed to assist a resident at eye level during a meal reviewed for dignity. An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings customer services and respect towards residents. The DON further revealed she did not know why these incidents had occurred. F 580: Based on record review, resident, Infusion Center Nurse, Nurse Practitioner, Medical Director, and staff interviews the facility failed to notify the physician of a facility-initiated discharge for 1 of 3 residents (Resident #1) reviewed for notification. On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. During the complaint investigation survey of 02/15/24 the facility failed to notify the Physician	F 867	4/11/2024, the Director of Nursing was re-educated by the Regional Clinical Director on notification to the physician for residents who have gone on a therapeutic leave, physician appointment or leave of absence for any resident who would not be allowed to return to the center after the appointment. On 4/11/2024, the Vice President of Operations re-educated the Nursing Home Administrator, Director of Nursing and Admissions Director on the centers policy allowing residents to return to the center from a a physician appointment, therapeutic leave or leave of absence. On 4/17/2024, the Director of Nursing and Social Service Director were re-educated by the Regional Clinical Director on ensuring the resident and/or responsible party has received communication on the purpose of the appointment and should the resident and/or responsible party choose to discharge from the appointment all discharge paperwork and instructions have been arranged prior to leaving the center. By 4/17/2024, the Regional Clinical Director re-educated the licensed nurses, the Social Services Director, Rehabilitation Director, Activities Director, Maintenance Director, Business Office Manager, Human Resource Manager, Receptionist Staff, Minimum Data Set Director, Unit Managers, Licensed Nurses and Business Office Staff were re-educated on the residents right to return to the center after a physician appointment, therapeutic leave or leave of absence.	

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F 867	Continued From page 37 of a resident's wound upon admission and failed to notify the Physician when the resident's wound had started to deteriorate. An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings notification. The DON further revealed nursing staff had failed to make appropriate notification and would continue to educate and put rules in place for proper notification. F 624: Based on record review and resident, Resident Representative,staff, Infusion Center staff, Nurse Practitioner, and Medical Director interviews the facility failed to provide a safe and orderly discharge for 1 of 3 residents (Resident #1). On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Resident #1 was not provided with discharge paperwork or discharge instructions and did not understand what was happening. The discharge location was not verified, home health services were not ordered at the time of discharge, and the resident was not followed up with to ensure his needs were met. This resulted in Resident #1 feeling like he was being thrown out, abandoned, and was mad. During the complaint investigation survey of 02/15/24 the facility failed to meet the resident's care needs upon discharge by not communicating the physician ordered wound care treatments and ensuring the needed medical equipment was delivered for a resident reviewed for a safe and	F 867	3 On 4/11/2023, a Quality Assurance and Assessment/Quality Assurance and Performance Improvement meeting was conducted by the Vice President of Operations, Director of Clinical Services and Regional Clinical Director on the components for citations F550, F580 and F624. The Nursing Home Administrator, Director of Nursing, Social services Director, Activity Director, Rehabilitation Therapy Director, Admissions Director, Maintenance Director, Staff Development Coordinator, Unit Managers, Infection Preventionist, Minimum Data Set Coordinators, Business Office Manager, Environmental Services Manager and Certified Dietary Manager were re-educated in the process to review the audits and ensure future recommendations to improve the current practice and track performance ensuring compliance is achieved through the monthly Quality Assurance and Assessment/Quality Assurance and Performance Improvement process. 4 Starting on 4/16/2024, the Nursing Home Administrator will present the findings of the Quality Assurance and Assessment/Quality Assurance and Performance Improvement committee meeting minutes monthly to the Vice President of Operation and Regional Clinical Director to ensure compliance with agenda items to include F550, F580 and F624. This review will continue for a period of 6 months.	

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F 867	Continued From page 38 orderly discharge. An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings about safe and orderly discharges. The DON further revealed she could not recall why discharges had been an issue, but steps would be put into place to guarantee residents would not be discharged unsafe in the future.	F 867		