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	345304	A. BUILDING _____ B. WING _____	C 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(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 onsite recertification and complaint investigation survey was conducted from 04/15/24 through 04/18/24. The survey team returned to the facility on 05/07/24 to validate immediate jeopardy removal plans. Therefore, the exit date was changed to 05/07/24. Event ID# PD8C11. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PD8C11.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 04/15/24 through 04/18/24. The survey team returned to the facility on 05/07/24 to validate immediate jeopardy removal plans. Therefore, the exit date was changed to 05/07/24. Event ID# PD8C11. The following intakes were investigated: NC00215957, NC00214912, NC00214023, NC00213800, NC00209432, NC00209221, NC00207243, NC00206310, NC00206075, NC00206069, NC00205728, NC00205370, NC00205306, NC00205210, NC00205090, NC00204870, NC00204161, NC00203910, NC00203838, NC00203318, NC00202260, and NC00202178. 19 of the 71 complaint allegations resulted in deficiencies. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at scope and severity (K) Immediate Jeopardy began on 04/02/24 and was removed on 04/28/24. CFR 483.25 at tag F689 at scope and severity (K)	F 000		

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

Electronically Signed | 05/17/2024

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F 000	Continued From page 1 Immediate Jeopardy began on 02/21/24 and was removed on 04/28/24. CFR 483.45 at tag F760 at scope and severity (K) Immediate Jeopardy began on 04/02/24 and was removed on 04/27/24. CFR 483.60 at tag F812 at scope and severity (K) Immediate Jeopardy began on 04/16/24 and was removed on 04/19/24. CFR 483.80 at tag F880 at scope and severity of (J) Immediate Jeopardy began on 07/10/23 and was removed on 04/19/24. The tags F689 and F760 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 580 SS=K	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	F 580		5/8/24

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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, 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:

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F 580	Continued From page 3 Based on record reviews, staff, responsible person (RP) and Medical Director (MD) interviews, the facility failed to notify the MD when multiple doses of significant morning medications (seizure medication, insulin, depression medication, and chronic kidney and heart failure medication) were not administered due to Resident #20 being out of facility for dialysis treatment and not administered her morning medications. There was a high likelihood of failure to administer these medications could have resulted in non-therapeutic levels resulting in seizure activity, high blood sugars which could lead to diabetic coma, and increased blood pressure and heart rate which could lead to stroke and cardiac complications. Additionally, the facility failed to notify the Responsible Person (RP) for Resident #66 when Resident #66 who was severely cognitively impaired with a history of wandering was observed by Nursing Assistant (NA) #6 attempting to cut her cast off her left arm using a "long ridged knife with handle." This deficient practice affected two of three sampled residents reviewed for notification (Resident #20 and #66). Immediate jeopardy began on 4/02/24 when the facility failed to notify the physician when medications scheduled for morning administration (a seizure medication, insulin, a depression medication, and a chronic kidney and heart failure medication) were not administered on multiple occasions to Resident #20. Immediate jeopardy was removed on 4/28/24 when the facility implemented an acceptable credible allegations of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate	F 580	Based on record reviews, staff, responsible person (RP) and Medical Director (MD) interviews, the facility failed to notify the MD when multiple doses of significant morning medications (seizure medication, insulin, depression medication, and chronic kidney and heart failure medication) were not administered due to Resident #20 being out of facility for dialysis treatment and not administered her morning medications. 1. Resident #20 is receiving all medications timely regardless of being out of facility for dialysis. 2. All residents have the potential to be affected by the deficient practice. An audit was conducted on 4/26/24 of all dialysis residents to ensure that they were receiving their medications timely. Results of the audit confirmed that all residents were receiving their medications at the specified time. 3. Re-Education was conducted by the Director of Nursing and the Assistant Director of Nursing on 4/24/24 with all licensed nursing staff regarding the policy of physician notification regarding missed medications due to residents being out of the facility for any reason. 4. Three licensed nurses will be interviewed by the Director of Nursing weekly for six week regarding the policy of physician notification. The results of the interviews will be reported to the QA committee monthly for three months.	

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jeopardy to ensure monitoring systems and staff education put into place are effective.

Example #2 for Resident #66 was cited at a scope and severity of D.

Findings included:

1. Resident #20 was admitted to the facility on 01/16/18 with diagnoses to include renal dialysis dependence, heart failure, seizure disorder, depression, and diabetes. Resident #20 also received scheduled dialysis treatments outside of the facility on Tuesday, Thursday, and Saturday and would leave the facility for these treatments at 5:30 AM and return to the facility at 10:30 AM.

Review of physician orders for significant medication for Resident #20 are as follows:

Escitalopram 20 milligrams (MG), give 1 tablet by mouth one time a day related to depression;
Keppra 24 hour extended release 500 MG, give 1 tablet by mouth one time a day related to epilepsy;
Ozempic 1 MG solution pen-injector, inject subcutaneously (beneath the skin) 1 time a day every Thursday related to type 2 diabetes;
Carvedilol 25 MG, give 1 tablet by mouth 2x's daily for hypertensive heart disease and chronic kidney disease with heart failure; and
Humalog 100-unit/ milliliter (ML) solution pen-injector, inject subcutaneously per sliding scale before meals and at bedtime related to type 2 diabetes.

Review of the Medication Administration Record (MAR) dated April 2024 revealed dates of Resident #20 not receiving significant morning

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medications due to being out of the facility for scheduled dialysis treatments. Per Resident #20's April 2024 MAR, missed doses of scheduled significant morning medication are as follows:

Escitalopram (9 AM) - Tuesday 4/02, Thursday 4/11, Tuesday 4/16
Keppra (8 AM) - Tuesday 4/02, Tuesday 4/09, Thursday 4/11, Tuesday 4/16
Ozempic (9 AM) - Thursday 4/11
Carvedilol (7:30 AM) - Tuesday 4/02, Tuesday 4/09, Thursday 4/11, Tuesday 4/16
Humalog and blood sugars (7:30 AM) - Tuesday 4/02, Tuesday 4/09, Thursday 4/11, Saturday 4/13, Tuesday 4/16

Per the manufacturer label warnings, failure to administer these medications could have resulted in non-therapeutic levels resulting in seizure activity, high blood sugars which could lead to diabetic coma, increased blood pressure and heart rate which could lead to stroke and cardiac complications, anxiety, and irritability.

Review of Resident #20's April 2024 nursing progress notes revealed no documentation of the MD being notified of the missed medications.

A telephone interview was conducted with the MD on 04/17/24 at 4:24 PM. The MD revealed that he had not been made aware of Resident #20 not receiving her morning medications on the days she received dialysis. He stated all dialysis residents should be administered any medications missed while at dialysis upon their return. The MD also stated that he would have expected the facility to notify him if a resident's dialysis treatments were conflicting with when a medication was ordered to be administered so he

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could adjust the medications and their times to be administered. Due to having no knowledge of Resident #20 not being administered morning medications on days where she had received dialysis treatments, he was not able to comment on any outcome it caused or could have caused and whether those would have been significant or not.

An interview was conducted with the Administrator and Director of Nursing (DON) on 04/18/24 at 12:20 PM revealed they were not aware Resident #20 had missed her medications. The Administrator stated nursing staff had been educated that anytime a medication is not administered to a resident for whatever reason they were to notify the physician, the supervisor and document. The DON revealed all dialysis residents should be administered their scheduled medications upon their return to the facility and any issues with not being able to administer those medications should be reported immediately to the physician for recommendations on how to proceed, the nursing supervisor and documented.

The Administrator was notified of immediate jeopardy on 04/26/24 at 1:07 PM.

The facility provided the following plan for IJ removal.

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

The facility failed to notify the Medical Director of missed/omitted significant medications prescribed for Resident #20 to treat diabetes, epilepsy and hypertensive heart disease and chronic kidney

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disease with heart failure, and depression. Nurse #13 and Nurse #15 did not notify the medical provider of the missed/omitted significant medications.
On 4/18/24 Nurse #13 received verbal 1 on 1 education by Director of Nursing (DON) on policy regarding notification of provider and resident representative promptly upon any resident change in condition, clinical complications, or need to alter treatment significantly. Education also included notifying the medical provider regarding missed significant medications when a resident is out of the facility when these medications are due to be administered. Nurse #13 verbalized understanding of re-education.
On 4/18/24 facility Medical Director (MD) was notified by DON of Resident #20's identified medication omissions. An order was obtained from MD to administer all prescribed medications upon return from dialysis for all residents in the facility who receive dialysis treatment.
The DON completed an audit on 4/18/24 of all residents receiving dialysis services back 4/1/24 to ensure no other significant medication errors. Any errors identified were reported to MD.
On 4/27/24 DON completed an audit of all residents' Medication Administration Records back to 4/1/24 for med errors/omissions and reviewed incident reports to ensure notification of responsible party/family and MD was completed.
The Director of Nursing reviewed electronic health care record dashboard back to 4/1/24, which reflects resident's changes in conditions, new medication orders, omitted medications as well as risk management dashboard for incidents and accidents to ensure notification to resident's responsible party and the medical practitioner.

Specify the action the entity will take to alter the

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process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

4/24/24 Quality Assurance Performance Improvement (QAPI) meeting was held by Administrator (LNHA) with all department heads on policy regarding notification of provider and resident representative promptly upon any resident change in condition, clinical complications, or need to alter treatment significantly and MD via phone. Notification Policy was reviewed during QAPI.
Education/audits/monitoring were discussed. MD and Department Heads verbalized understanding. The Notification Policy did not require revisions at this time.

On 4/24/24 in person education began with all licensed nurses (including Nurse #15) and medication aides including agency nurses and medication aides by DON/ Assistant DON (ADON)/Nurse Managers on policy regarding notification of medical provider and resident representative promptly upon any resident change in condition, clinical complications, or need to alter treatment significantly, including medications missed/omitted. Education also included notification to medical provider for all missed or omitted medications for residents out of the facility and/or on leave of absence. All staff verbalized understanding. Education to all remaining licensed nurses and medication aides was completed by DON on 4/24/24 via phone and/or in person. All staff not educated on 4/24/24 will be educated by DON/ADON/Nurse Manger prior to the start of their next shift. The DON will be responsible for maintaining an employee tracking log to identify staff that still

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require education. All newly hired nurses and medication aides, including agency nurses and medication aides, will receive this education from the DON/ADON during the orientation process. The Nurse Manager on duty will provide verbal education to any agency staff member that works after 4/24/24 prior to accepting shift assignment. DON/ADON/Nurse Managers were made aware of this responsibility by the Administrator on 4/24/24. The DON will notify the Nurse Managers when there is a new agency nurse or medication aide that requires the education.

Alleged date of immediate jeopardy removal: 4/28/24

A validation of immediate jeopardy removal was conducted on 05/07/24. The audit of all dialysis residents was reviewed and verified that each resident that received dialysis had an ordered entered into their medical record that indicated all prescribed medications were to be given upon return from dialysis treatment. Each resident's care plan was also updated and verified as a part of the removal verification process. Staff in-service records and interviews with nursing staff confirmed they were educated on the requirement of notification to the medical provider and responsible party when medications were missed or omitted. The facility's QA committee met on 04/24/24 and reviewed the policy on notification which did not require any revisions. The QA verbalized understanding of the policy and requirement. Audits completed from 04/28/24 through 05/06/24 were reviewed with no new issues identified. The facility's removal date of 04/28/24 was validated.

2. Resident #66 was admitted to the facility on

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02/16/24 with diagnosis that included a left arm fracture and dementia.

An interview with Nursing Assistant (NA) #6 on 4/17/24 at 9:00 AM revealed she had been employed at the facility since August 2023 and was familiar with Resident #66. She stated on 2/21/24 she was walking up the resident 200 hall and observed Resident #66 standing right outside of the maintenance room (located at the top of the 200 hall between the utility room and beauty parlor), the door was unlocked and cracked open. Resident #66 had a "long ridged knife with a handle" in her right hand and using a back-and-forth motion was attempting to cut off the cast located on her left arm. The NA stated she assumed Resident #66 had gotten the knife from inside the maintenance room since that was where she was standing. NA #6 revealed she asked Resident #66 to hand her the knife, which she did with no issues and placed it back inside the maintenance room and shut the door. She assessed Resident #66's body for any injuries, and walked her back to her room where she assessed her again for any injuries and did not observe any visible injuries and Resident #66 had no complaints of pain. NA #6 stated she did not recall if she informed any of the nurses on the hall but did report the incident to the DON. She revealed Resident #66 had a history of wandering all the halls in the facility and would stop at each room and try and turn all the door handles to see if they would open. She stated she had no knowledge of what occurred after she notified the DON of the incident, and she did not lock the maintenance door back and was not aware if anyone else locked the maintenance door after the incident or why the maintenance door had been unlocked in the first place.

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Review of Resident #66 progress notes from February 2024 to present revealed no documentation of incident or notification of incident to Resident #66's Responsible Party (RP) or the Medical Director.

An interview with Resident #66's RP on 04/17/24 at 10:45 AM revealed she had not been notified of the incident with Resident #66 standing outside of the unlocked maintenance room attempting to cut the cast off of her left arm with a ridged knife on 2/21/24. She stated she would have liked to have been notified of the incident so that she could have come to the facility to assess Resident #66 herself, address any issues and make sure that Resident #66 was safe and unharmed.

A telephone interview was conducted with the MD on 04/17/24 at 4:24 PM. The MD revealed that he had not been made aware of the incident with Resident #66 that occurred on 2/21/24 and would have preferred the facility to notify him or the nurse practitioner about the incident so they could have discussed any change in behavior or condition, possible treatments, or medication changes.

An interview with the Administrator and Director of Nursing (DON) on 04/18/24 at 12:20 PM revealed the Administrator had not been made aware of the incident and the DON did not recall being notified of the incident with Resident #66. The Administrator stated anytime an event such as a behavioral incident or accident occurs with a resident, nursing staff should notify their supervisors immediately and document the event so they can investigate the incident properly,

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F 580	Continued From page 12 provide notifications to the residents' RP and family, and make sure the correct precautions or treatment are put into place. The Administrator and DON revealed Resident #66's RP should have been notified of the incident when it occurred.	F 580		
F 583 SS=D	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. §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	F 583		5/18/24

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F 583	Continued From page 13 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 record review, resident, family, and staff interview the facility failed to protect Resident #172's private health information when her insulin pen was left at the bedside of another resident for 1 of 2 residents reviewed for privacy and confidentiality. The findings included: Resident #171 was admitted to the facility on 04/22/23 and was discharged on 09/06/23. Resident #171's diagnoses included diabetes mellitus. Review of the comprehensive Minimum Data Set (MDS) dated 06/30/23 revealed that Resident #171 was cognitively intact. Resident #171 was interviewed via phone on 04/15/24 at 4:31 PM. Resident #171 stated that on 07/10/23 at 6:06 PM Nurse #10 came into her room to give her an insulin shot. She stated Nurse #10 had laid the cap to the insulin pen on her bedside table and after she had given the insulin shot to Resident #171, she (Resident #171) noted that the label that was on the insulin pen cap had Resident #172's name on it. A picture provided by Resident #171 on 04/15/24 at 4:59 PM revealed an Insulin Pen with a label that contained Resident #172's name, room number, type of insulin, prescription number and fill date. The type of insulin was Lispro insulin	F 583	Based on record review, resident, family, and staff interview the facility failed to protect Resident #172's private health information when her insulin pen was left at the bedside of another resident for 1 of 2 residents reviewed for privacy and confidentiality. 1. Resident #172 is no longer at the facility. 2. All residents have the potential to be affected by the deficient practice. On 4/18/24 the Director of Nursing and Nurse Managers conducted an audit of all residents receiving insulin via the insulin pen and verified that all insulin pens were removed from the bedside and stored in the medication cart. 3. Education by the Assistant Director of Nursing/designee was completed with all staff by 5/17/24. All newly hired staff members and agency staff will be educated during orientation process by ADON/designee. 4. The facility will maintain compliance by rounding and making random observations of resident rooms to ensure no resident information is left visible to others. Audits will be conducted 2 times per week for 6 weeks beginning 4/22/24. The Director of Nursing will review the rounds and report any discrepancies to the QA Committee monthly for three	

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F 583	Continued From page 14 (fast acting insulin). Resident #171's family member was interviewed via phone on 04/16/24 at 5:03 PM. The family member stated that Resident #171 had called and had sent her a picture of the insulin pen belonging to Resident #172. The family member stated she reported the issue to the Director of Nursing (DON) in July after the incident occurred. The DON was interviewed on 04/18/24 at 2:47 PM. The DON stated that all staff were responsible for ensuring the protection of protected health information. And in this situation the prudent thing to have done was ensure that no protected health information was left for another resident to see it.	F 583	months.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff	F 600	Based on record review, and resident and	5/18/24

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F 600	Continued From page 15 interviews the facility failed to protect a resident's right to be free from inappropriate physical contact by a staff member. On 4/1/24 Nurse Aide (NA) #1 was observed lying in bed with Resident #46. This deficient practice occurred for 1 of 5 residents reviewed for abuse, neglect, and exploitation. The findings included: The facility Abuse/ Neglect and Exploitation Policy read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion. The initial allegation report dated 4/10/24 included in part, It was reported that an agency Nurse Aide #1, got into the bed with Resident #46 and allowed him to touch on her. Nurse Aide #1 has been suspended pending investigation. Resident #46 was readmitted to the facility on 11/15/23 with diagnoses that included depression and legal blindness. A quarterly Minimum Data Set assessment (MDS) dated 2/6/24 indicated Resident #46 was cognitively intact, and severely impaired vision/ legally blind. During an interview on 4/15/24 at 2:25 pm Resident #46 indicated at about 2:00 am a few weeks prior (couldn't recall exact date) he was awakened to a voice and believed the person	F 600	staff interviews the facility failed to protect a resident's right to be free from inappropriate physical contact by a staff member. On 4/1/24 Nurse Aide (NA) #1 was observed lying in bed with Resident #46. This deficient practice occurred for 1 of 5 residents reviewed for abuse, neglect, and exploitation. 1. Staff member was working for agency and has been released from the facility. 2. All residents at the facility have the potential to be affected by the deficient practice. All residents were interviewed on 4/10/24 by the both the Director of Social Services and their floor nurse regarding any inappropriate touching and whether or not they feel safe at the facility. No residents reported being inappropriately touched or being afraid of employees at the facility. Skin assessments were completed by 4/10/24 for residents who were unable to be interviewed. No issues were identified. Additionally, all staff members were interviewed by the Director of Nursing and the Administrator on 4/10/24 if they were aware of any staff members getting into bed with a resident and if they were aware of the abuse policy and who to report abuse to. No staff members were aware of a staff member getting into bed with a resident. All confirmed that they were aware of the abuse policy and knew to whom abuse should be reported. 3. All staff members were re-educated by 5/17/24 by the Director of Nursing and Administrator regarding the abuse policy. Beginning 5/17/24 all agency staff will be re-educated prior to next shift. All newly	

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F 600	Continued From page 16 may have been on the phone. Resident #46 stated he was blind and did not know who the person was. Resident #46 stated he did not know for sure if the person was in his bed with him or if the person was sitting on the bed. He stated the person who he later identified as NA #1, was also talking to another NA (NA #3) who was with his roommate. Resident #46 recalled NA #1 called him (Resident #46's) by name and stated, "I'm sorry am I waking you up?" Resident #46 stated he told NA #1 "no." Resident #46 stated he never touched NA #1 intentionally and NA #1 never touched him. During a follow up interview on 4/17/24 at 2:34 pm Resident #46 revealed he may have touched NA#1 on her thigh and quickly removed it when he realized there was someone in or on his bed. Resident #46 recalled NA #1 was talking to a NA on the other side of the room when he was awakened, then inadvertently touched NA #1 on the thigh and NA #1 stated "I'm sorry, did I wake you?" Resident #46 stated he was not bothered that NA #1 was in his bed and indicated that she may have been lying down at first. During a phone interview on 4/17/24 at 3:06 pm NA #1 revealed she worked from 11:00 pm on 3/31/24 to 7:00 am on 4/1/24 and was assigned to Resident #46 as the one-to-one sitter. NA #1 stated Resident #46 was asleep when she arrived for her shift, and she relieved the previous sitter. NA #1 stated NA #3 took breaks during the night and she monitored his resident who was also on one-to-one. NA #1 stated throughout her shift, she sat in a chair at the foot of Resident #46's bed and that Resident #46 awakened about 2-3 times during the night to request ice water. NA #1 stated she never sat on or laid in Resident #46's	F 600	hired staff will be educated during orientation process by ADON/designee. 4. Five staff members will be randomly interviewed by the Director of Nursing regarding the abuse policy and to whom and when to report abuse monthly for at least three months. Results of the interviews will be reported to the QA committee monthly for recommendations for three months.	

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F 600	Continued From page 17	F 600		

bed, she never touched Resident #46, she was never talking on her cell phone, and she never asked Resident #46 if she "woke him up". NA #1 stated numerous people told her that a rumor was going around that she was in bed with Resident #46, and they were touching each other. NA #1 further revealed she did not know why NA #3 and Resident #46 would have made those statements. NA #1 also stated she had never been accused of sleeping on her shift.

During a telephone interview on 4/17/24 at 1:35 pm Nurse Aide (NA) #3 revealed worked a double shift (3pm -11pm and 11pm- 7am) on 3/31/24 and was he was assigned as the one-to-one sitter (11pm- 7am shift) for Resident #46's roommate who occupied bed A (which was closest to the door), and the privacy curtain was pulled between the beds to allow privacy of both residents as they slept. NA #3 stated NA #1 was assigned as the one-to-one sitter for Resident #46. NA #3 further revealed between 1:30 am and 2:00 am he stood up from his chair, walked around the privacy curtain and was about to ask NA #1 to monitor the bed A resident while he (NA #3) went on break when he observed NA #1 lying in bed with Resident #46. NA #3 stated he observed NA #1 lying on her back with eyes closed and Resident #46 also appeared to be asleep. Resident #46's had his right hand resting under NA #1's breasts. NA #3 indicated he stated to NA #1 "Girl, what are you doing?" and NA #1 opened her eyes and did not respond verbally. Instead, she shrugged her shoulders and propped her arm behind her head. NA #3 stated he left the room to go on break, stopped at the nurse's station and stated to Nurse #13, "Yall need to go check on Resident #46." NA #3 recalled Nurse #13 responded "Why what's wrong with him?" NA #3 stated he informed

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F 600	Continued From page 18	F 600		

Nurse #13 there was nothing wrong with Resident #46, but NA #1 was lying in bed with him. NA #3 stated when he returned to Resident #46's room, NA #1 was sitting in the chair next to bed A, then got up, returned to Resident #46's side of the room (bed B), sat in a chair and did not say anything further to him (NA#3).

During an interview on 4/18/24 at 2:45 pm Nurse #13 indicated she worked 3/31/24 to 4/1/24 (11pm -7am shift). On 4/1/24, she overheard NA #3 talking about NA #1 lying in bed with Resident #46 and when she went to see herself, NA #1 was sitting in a chair in Resident #46's room. Nurse #13 further indicated she asked NA #1 if everything was okay and did not specifically ask NA #1 if she had been lying in bed with Resident #46.

During a telephone interview on 4/17/24 at 5:51 pm Unit Manager #1 indicated on 4/10/24, she overheard staff talking about NA #1 lying in the bed with Resident #46 on the overnight shift on 4/1/24. Unit Manager #1 further indicated she reported the incident to the DON on 4/10/24.

During an interview on 4/18/24 at 3:30 pm the DON revealed she was made aware of the incident that involved Resident #46 and NA #1 on 4/10/24. The DON stated her expectation was for all residents to be protected from abuse, neglect, exploitation, and inappropriate physical contact was not acceptable. The DON further stated staff have been educated on the abuse policy.

During an interview on 4/18/24 at 3:25 pm the Administrator indicated she had not been made aware of the incident that occurred between NA #1 and Resident #46 until 4/10/24 and that the

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F 600	Continued From page 19 incident took her by surprise because staff were always calling her about everything else that occurred in the facility. The Administrator further indicated she expected all residents to be free from abuse, neglect, exploitation, misappropriation, and inappropriate physical contact was not acceptable.	F 600		
F 607 SS=D	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, §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	F 607		5/18/24

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F 607	Continued From page 20 (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews the facility failed to follow their policy in the areas of reporting and protection. The facility failed to immediately report inappropriate staff to resident physical contact when Nurse Aide (NA) #1 was observed by another staff member (NA #3) lying in bed with Resident #46. NA #1 continued to work shifts on 4/1/24, 4/5/24, 4/6/24, 4/7/24. One of 5 residents were reviewed for abuse. The findings included: The facility Abuse/ Neglect and Exploitation Policy read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion. The facility shall have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within 2 hours after the allegation is made if the allegation involved abuse or resulted in serious bodily injury or no later than 24 hours if the event that caused the allegation did not involve abuse and did not result in serious bodily injury. Resident #46 was readmitted to the facility on 11/15/23 with diagnoses that included depression, type 2 diabetes, bilateral glaucoma, legal	F 607	Based on record review, resident interviews and staff interviews the facility failed to follow their policy in the areas of reporting and protection. The facility failed to immediately report inappropriate staff to resident physical contact when Nurse Aide (NA) #1 was observed by another staff member (NA #3) lying in bed with Resident #46. NA #1 continued to work shifts on 4/1/24, 4/5/24, 4/6/24, 4/7/24. One of 5residents were reviewed for abuse. 1. Staff member who failed to notify Director of Nursing regarding staff member being found in bed with resident was immediately re-educated on abuse reporting timelines on 4/10/24. 2. All residents have the potential to be affected by the deficient practice. All staff members were interviewed by the Director of Nursing and the Administrator on 4/10/24 to determine if they were aware of any staff members getting into bed with a resident and if they were aware of the abuse policy regarding to whom they were to report abuse and the required timeline for mandatory reporting. All confirmed that they were aware of the abuse policy, knew to whom abuse should be reported and were aware of the required timeline for reporting. 3. All staff members were re-educated by 5/17/24 by the Director of Nursing and Administrator regarding the abuse policy. Beginning 5/17/24 all agency staff will be re-educated prior to next shift. All newly	

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F 607	Continued From page 21 blindness, and dependence on renal dialysis. A quarterly Minimum Data Set assessment (MDS) dated 2/6/24 indicated Resident #46 was cognitively intact, independent of care needs, had adequate hearing, clear speech, and severely impaired vision/ legally blind. During an interview on 4/15/24 at 2:25 pm Resident #46 indicated he heard a lot of people stated he was in bed with a staff member. He further indicated about 2:00 am a few weeks prior (couldn't recall exact date) when he had planned to go to dialysis the following morning, he was awakened to a voice and believed the person may have been on the phone. Resident #46 stated he was blind and did not know who the person was. Resident #46 stated he did not know for sure if the person was in his bed with him or if the person was sitting on the bed while he laid in the bed. He stated the person who he later identified as a female, was also talking to another NA who was with the resident in bed A. Resident #46 recalled NA #1 called him (Resident #46's) by name and stated, "I'm sorry am I waking you up?" Resident #46 stated he told NA #1 "no." Resident #46 stated he never touched NA #1 intentionally and NA #1 never touched him. Resident #46 stated NA #1 was sat on his bed for 10-15 minutes. During a follow up interview on 4/17/24 at 2:34 pm Resident #46 revealed he may have touched NA#1 on her thigh and quickly removed it when he realized there was someone in or on his bed. Resident #46 recalled NA #1 was talking to a NA on the other side of the room when he was awakened, then inadvertently touched NA #1 on the thigh and NA #1 stated "I'm sorry, did I wake	F 607	hired staff will be educated during orientation process by ADON/designee. Beginning 5/17/24 facility will respond to protect the resident by immediately relieving any staff member named in an allegation of abuse from duties pending investigation per facility policy. 4. Five staff members will be randomly interviewed by the Director of Nursing regarding the abuse policy and to whom and when to report abuse monthly for at least three months. Results of the interviews will be reported to the QA committee monthly for recommendations for three months.	

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you?" Resident #46 stated he was not bothered that NA #1 was in his bed and that she may have been lying down at first.

During a telephone interview on 4/17/24 at 1:35 pm NA #3 revealed he worked a double shift (3pm -11pm and 11pm- 7am) on 3/31/24 and was he was assigned as the one-on-one sitter (11pm-7am shift) for Resident #46's roommate who occupied the first bed (bed A). NA #3 stated NA #1 was assigned to one-on-one sitter for Resident #46. NA #3 further revealed between 1:30 am and 2:00 am he stood up from his chair, walked around the privacy curtain and was about to ask NA #1 to monitor the bed A resident while he (NA #3) went on break when he observed NA #1 lying in bed with Resident #46. NA #3 stated he observed NA #1 lying on her back with eyes closed and Resident #46 also appeared to be asleep as his right hand rested under NA #1's breasts. NA #3 indicated he stated to NA #1 "Girl, what the hell are you doing?" and NA #1did not respond verbally. Instead, she shrugged her shoulders as if she did not care and propped her arm behind her head. NA #3 stated he left the room to go on break, stopped at the nurse's station and stated "Yall need to go check on Resident #46." NA #3 recalled Nurse #13 responded "Why what's wrong with him?" NA #3 stated he informed Nurse #13 there was nothing wrong with Resident #46 but NA #1 was lying in bed with him. NA #3 stated when he returned from his smoke break, Nurse #13 stated she observed Nurse Aide #1 sitting on the side of the resident's bed and did not observe her lying in the bed with the resident. NA #3 stated since he was the only one who observed NA #1 in the bed with the resident, he figured it would be viewed as his word against NA #1's word. NA #3 stated when

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he returned to Resident #46's room, NA #1 was sitting in the chair next to bed A, then got up, returned to Resident #46's side of the room (bed B), sat in a chair and did not say anything further to him (NA#3). NA #3 stated the next morning (4/1/24) he told a few other staff who worked that night, about the incident but was unsure who he told. NA #3 stated when he returned to work another shift on 4/1/24 (3p-11p), Resident #46 was on the smoking patio talking/ joking about the incident and how he thought he was dreaming that there was someone in his bed the previous night, until he felt breasts and that's when he (Resident #46) knew there really was someone in his bed. NA #3 stated he reported the incident to Nurse #13 and did not report the incident to the assigned nurse, Director of Nursing, or the Administrator because he thought the supervisors already knew about it.

During an interview on 4/17/24 at 3:47 pm NA #4 revealed she overheard other staff talking about the NA #1 being observed asleep in bed with Resident #46 and thought it was a joke, although she reported it to the assigned nurse (Nurse #14).

Attempts to contact Nurse #14 were unsuccessful.

During a telephone interview on 4/17/24 at 5:51 pm Unit Manager #1 indicated on 4/10/24 she overheard staff talking about the incident from 3/31/24 whereas NA #1 was observed lying in bed with Resident #46. Unit Manager #1 further indicated she reported the incident to the DON on 4/10/24.

During an interview on 4/18/24 at 2:45 pm Nurse #13 indicated she overheard NA #3 talking about

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the incident on 3/31/24 (11 pm- 7 am shift) and when she went to see herself, NA #1 was sitting in a chair in Resident #46's room. Nurse #13 further indicated she asked NA #1 if everything was okay and did not specifically ask if NA #1 was asleep in bed with Resident #46. Nurse #13 stated she felt there was nothing to report to her supervisor since she did not observe NA #1 in asleep in bed with Resident #46. Nurse #13 explained the next day 4/1/24, she heard more "rumors" about NA #1 being in bed with Resident #46 and thought the supervisors and/ or Director of Nursing (DON) were already aware of the incident. Nurse #13 stated she was just realizing that she could have reported the incident to the DON or Administrator instead of assuming the "rumor" was a joke or that leadership had already been made aware of the incident.

During an interview on 4/17/24 at 3:47 pm NA #4 revealed she overheard other staff talking about the NA #1 being observed asleep in bed with Resident #46 on 4/1/24 and thought it was a joke. NA #1 further revealed she reported the incident to the assigned nurse (Nurse #14) during the overnight shift 3/31/24 to 4/1/24.
Attempts to contact Nurse #14 were unsuccessful.

A review of the Facility Reported Incident investigation file dated 4/10/24 and NA #1's timecard indicated NA #1 continued to work shifts on 4/1/24, 4/4/24, 4/6/24 and 4/7/24 after the incident occurred and was reported on 3/31/24 (11pm- 7am shift).

During an interview on 4/18/24 at 3:30 pm the DON revealed on 4/10/24 she was made aware of the incident that involved Resident #46 and NA

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F 607	Continued From page 25 #1. The DON further revealed the facility submitted an initial allegation report and NA #1 was suspended. The DON stated her expectation was for all residents to be protected from abuse, neglect, and exploitation. The DON further stated all staff who were made aware of the incident since 4/1/24 should have reported it immediately to their supervisor and/or the Administrator. During an interview on 4/18/24 at 3:25 pm the Administrator indicated she had not been made aware of the abuse incident until 4/10/24 and that the incident took her by surprise because staff were always calling her about everything else that occurred in the facility. She further indicated although the DON was on vacation during the week the incident occurred, the incident should have been reported to her (the Administrator) immediately. The Administrator stated she would have submitted an initial report, suspended the accused staff, and initiated a 5-day investigation to be sent to the State, according to the facility's abuse policy.	F 607		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (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	F 644		5/18/24

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F 644	Continued From page 26 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 refer two new residents with serious mental health diagnoses, and one resident with a new mental health diagnosis for Preadmission Screening and Resident Review (PASRR) level II for 3 of 3 residents reviewed for PASRR (Resident #4, #19, and #54). The findings include: 1. Review of Resident #4's medical record revealed the resident had a PASRR level I determination completed prior to his admission and was admitted to the facility on 04/06/23. The resident had been diagnosed with post-traumatic stress disorder (PTSD) and mental disorder during his admission. No PASRR level II referral documentation had been observed in Resident #4's medical records. An interview on 04/17/24 at 9:26 AM with the Social Worker (SW) revealed he had been employed as the facility SW since March 2024 and had received training on how to complete PASRR paperwork for residents. He stated he was not aware of Resident #4's mental health diagnosis or that a PASRR level II referral had not been completed. The SW revealed that based on the PASRR training he had received a PASRR level II referral should be completed upon	F 644	1. Based on record review and staff interviews the facility failed to refer two new residents with serious mental health diagnoses, and one resident with a new mental health diagnosis for Preadmission Screening and Resident Review (PASRR) level II for 3 of 3 residents reviewed for PASRR (Resident #4, #19, and #54). Residents were reviewed and updates were sent for new Level 2 PASRR determinations by the Social Services Director by 5/17/2024. 2. Audit was completed by 5/8/2024 by the Director of Nursing/Director of Social Work/designee to ensure accuracy of PASRR on all current residents with a mental health diagnosis. Any issues identified were addressed as indicated. 3. Education to Social Worker was completed by 4/18/2024 by the Administrator on the components of this regulation with emphasis on ensuring accuracy and timely reviews of residents PASARR. 4. Random audits will be conducted by the Administrator/designee 2x/week for 12 weeks to ensure accuracy of residents PASRRs. Results of audits will be discussed at the monthly Quality Assurance meeting for three (3) months	

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resident admission with a serious mental health diagnosis, when there was a change in condition or behavior, and when a resident had received a new mental health diagnosis. He also revealed that based on Resident #4's diagnosis of PTSD and mental disorder, the referral for a PASRR level II referral should have been completed.

An interview on 4/11/24 at 5:35 PM with the Administrator revealed a PASRR level II should be completed for a resident with a serious mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #4's admission diagnosis of PTSD and mental disorder, a PASRR level II referral should have been completed.

2. Review of Resident #19's medical record revealed the resident had a PASRR Level I determination completed prior to his admission and was admitted to the facility on 02/01/24. The resident had been diagnosed with psychotic disorder with hallucinations as part of his admission. No PASRR level II referral documentation had been observed in Resident #19's medical records.

During an interview on 04/17/24 at 9:26 AM with the Social Worker (SW) revealed he had been employed as the facility SW since March 2024 and had received training on how to complete PASRR paperwork for residents. He stated he was not aware of Resident #19 mental health diagnosis or that a PASRR level II referral had not been completed. The SW revealed that based on the PASRR training he had received a PASRR level II referral should be completed upon resident admission with a serious mental health

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diagnosis, when there was a change in condition or behavior, and when a resident had received a new mental health diagnosis. He also revealed that based on Resident #19's admission diagnosis of psychotic disorder with hallucinations, paperwork for a PASRR level II referral should have been completed.

An interview on 4/11/24 at 5:35 PM with the Administrator revealed a PASRR level II should be completed for a resident with a serious mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #19 admission diagnosis of psychotic disorder with hallucinations a PASRR level II referral should have been completed.

3. Review of Resident #54's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on 06/02/23. The resident had been diagnosed with adjustment disorder with mixed anxiety and depressed mood on 6/2/23 and depression disorder on 6/2/23 during her admission and received a new diagnosis of bipolar disorder on 09/01/23. No PASRR level II referral documentation had been observed in Resident #54's medical records.

During an interview on 04/17/24 at 9:26 AM with the Social Worker (SW) revealed he had been employed as the facility SW since March 2024 and had received training on how to complete PASRR paperwork for residents. He stated he was not aware of Resident #4 mental health diagnosis or that a PASRR level II referral had not been completed. The SW revealed that based on the PASRR training he had received a Level II

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F 644	Continued From page 29 PASRR should be completed upon resident admission with a serious mental health diagnosis, when there was a change in condition or behavior, and when a resident had received a new mental health diagnosis. He also revealed that based on Resident #54's diagnosis of adjustment disorder with mixed anxiety and depressed mood, depression disorder, bipolar disorder, paperwork for a PASRR level II referral should have been completed. During an interview on 4/18/24 at 12:15 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a serious mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #54 admission diagnosis of adjustment disorder with mixed anxiety and depressed mood, depression disorder and added diagnosis of bipolar disorder a PASRR level II should have been completed.	F 644		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679		5/16/24

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F 679	Continued From page 30 by: Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 5 of 5 residents reviewed for activities (Residents #203, #102, #114 #216 and #46). The residents expressed not being able to leave the facility made them feel frustrated, awful, forgotten about, hemmed in, angry, and mad. The residents further stated they hated being stuck in the building all the time and "once you get here, they won't let you leave." The findings included: A review of the January, February, March, April 2024 activity calendars revealed activities for inside of the facility during the week and on the weekends. There were no activities scheduled for outside of the facility. Review of Resident Council Meeting minutes from April 2023 through March 2024 residents had voiced the desire to go on outings occasionally during the June 2023 and September 2023 meetings. The residents were not named but it was documented they wanted to go shopping and out to eat. During a Resident Council Meeting conducted on April 17, 2024, at 3:05 PM Residents #203, #102, #114, #108, and #216 did have a desire to go out of the building. They reported they would like to go shopping and go out to eat, others suggested sporting events. The residents reported they really want to go out but were never offered any	F 679	1.Based on record review, facility activity calendar and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 5 of 5 residents reviewed for activities (Residents #203, #102, #114 #216 and #46). By 5/3 an outside activity was planned by Activities Director and offered to resident #203, #102, #114 #216 and #46. Resident #46 accepted and attended planned outside activity. 2. All residents have the potential to be affected by this deficient practice. By 4/23/2024 All residents were interviewed by Activities Director to inquire who had interest in attending outside of facility activities. Resident representatives were contacted for residents who were not interviewable. Care plans were updated for residents who preferred to attend outside of facility activities by 5/16/24. 3. On 4/22/24 Vice President of Operations re-educated Administrator and re-education was provided by Administrator to Activities Director on regulation to ensure that facilities implement an ongoing resident centered activities program that incorporates the resident□s interests and facility policy that activities will include individual, small and large group activities as well as indoor and outdoor activities and activities away from the facility.	

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F 679	Continued From page 31 outings as an activity. The residents stated they felt like once they were admitted that they were not allowed to leave again. The residents stated they had asked before to go on outings, but there was never a response to their request. The Administrator was present during the meeting at the residents' request and stated she was aware of the desire to go out, but that without transportation this was not possible. The Administrator told the residents she was working on trying to figure out a way to get them out but did not have a timeline. a. Resident # 203 was admitted to the facility on 07/13/23. An Admission Minimum Data Set (MDS) dated 07/20/23 indicated Resident #203 felt that it was somewhat important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #203 was cognitively intact. An interview as conducted with Resident #203 (Resident Council President) on 04/18/24 11:35 AM. The resident stated he wished they could go out on group outings and other residents have expressed the same to him. Resident #203 indicated he had reported this to the Administrator, but the residents had still not been offered an outing. Resident #203 further stated he could go out to the courtyard and visit, but he does not like not being able to go out of the facility for an activity. The resident reported that since he was admitted he has not been taken out of the facility for any activities and the only people that get to go out is people with families that take them out. Resident #203 said he was just	F 679	4. Interviews will be conducted 1x/weekly x12 weeks by Administrator/designee for 5 random residents to ensure activities to include outside of facility activities were offered and of interest. Results of audits will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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frustrated because getting to go on outings should not be so hard.

b. Resident #102 was admitted to the facility on 10/10/22.

An Admission Minimum Data Set (MDS) dated 10/15/23 indicated Resident #102 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #102 was cognitively intact.

An interview was conducted with Resident #102 on 4/18/24 at 10:13 AM revealed that she felt "hemmed in", would like to go out shopping, to Walmart or to eat at Cracker Barrel. Resident #102 stated it would make her feel happy. The interview further revealed she had mentioned this before during a resident council meeting however, they had not been out of the facility since the discussion. Resident #102 stated she had not been out of the facility for an activity since admission.

c. Resident #114 was admitted to the facility on 11/17/22.
An Admission Minimum Data Set (MDS) dated 11/24/22 indicated Resident #114 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #104 was cognitively intact.

An interview was conducted with Resident #114 on 04/18/24 at 10:15 AM revealed she would enjoy going out of the facility but wouldn't want to

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go out unless the facility was paying for the trip and meal. Resident #114 stated she had not been out of the facility on an outing since she was admitted to the facility. The resident reported that she hated being stuck in the building all the time and wished there were more chances to leave.

d. Resident #216 was admitted to the facility on 11/14/23.
An Admission Minimum Data Set (MDS) dated 11/21/23 indicated Resident #216 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #216 was cognitively intact.

An interview was conducted with Resident #216 on 04/18/24 at 09:53 AM. Resident #216 stated he felt angry and mad about being stuck in the nursing home and never having the opportunity to do things in the community. Resident #216 explained there were many pro football and pro basketball teams nearby that would probably donate tickets or food to the facility for the publicity. Resident #216 indicated he would even be willing to make the phone calls to make it happen. He further stated, "once you get here, they won't let you leave". Resident #216 revealed he had not been on an outing since he was admitted to the facility.

e. Resident #46 was readmitted to the facility on 11/15/23.

A quarterly Minimum Data Set assessment (MDS) dated 2/6/24 indicated Resident #46 was cognitively intact and had severely impaired vision/ legal blindness. The assessment further indicated doing favorite activities and doing things

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in a group setting were very important to Resident #46.

A revised care plan dated 12/12/23 indicated Resident #46 would attend/ participate in activities of choice through the next review period with interventions that included enjoying fresh air outside.

During an interview on 4/15/24 at 03:51 pm Resident #46 indicated he attended the bingo activity offered by the facility, however there were no planned activities outside of the facility because there was no transportation van for outings. Resident #46 further indicated there had not been a transportation for almost 2 years. Resident #46 stated he would like to participate in activities outside the facility such as the arcade or any place else, away from the facility.

During an interview on 4/17/24 at 9:39 am Nurse Aide (NA) #6 revealed she could not recall seeing the residents going on activities off the facility property and the facility did not have a van for transportation. NA #6 could not recall how long the facility had been without a transportation van and how long residents had not attended activities outside the facility. NA #6 further revealed she could recall the facility offered activities such as "coffee times in the morning" and bingo.

During a follow-up interview on 4/18/24 at 11:35 am Resident #46 stated not going on group outings made him feel awful, forgotten and that the facility did not have activities for a blind person to participate in. He further stated he would enjoy going to the arcade, the park to cook out when the weather was nice.

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During an interview on 4/18/24 at 2:25 pm the Activity Director indicated Resident #46 attended in-house activities such as bingo and due to his blindness, Resident #46 would receive assistance from staff during the activity. She was not aware how long the facility had been without a van and could only state there was no van since she started 5 months ago. The Activity Director stated Resident #46 attends an activity at a local blind services agency once a month and that agency provides transportation.

An interview on 04/18/24 at 02:16 PM with the Activity Director (AD) revealed she had been in current position for five months. The AD stated she has been told by the Administrator she had to wait for outings outside of the building until they got a van. The AD further stated that residents had requested to go out, but since the facility did not have a van for transportation, they had not been able to leave the facility. The Activity Director indicated she was not the staff member who does the shopping for the residents, but she did go on Wednesday afternoon and pick up the smokers' cigarettes for the week. The AD stated that residents had told her they would like to leave the facility for an activity, but she stated that the Administrator told her it was not an option right now so that was what she had reported to the residents. She reported that the residents told her they would like to go shopping and out to eat.

An interview with the Director of Nursing (DON) on 4/17/24 at 3:33 pm reported that the facility did not have an activity van. The DON stated they used a contracted transportation company, but this was only used for resident medical

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F 679	Continued From page 36 appointments. She was not sure when or if the facility would be buying a van. An interview with the Administrator on 4/17/24 at 3:45 PM revealed the facility did not have a van for transportation. The Administrator reported they were working on getting a van but was not sure when the corporate office was going to okay a new van. The Administrator stated she attends all the resident council meetings and was aware that residents wanted to go on outings, but she could not give a timeline as to when the facility might get a van. The interview further revealed the Administrator still had not come up with a way to meet this want. The Administrator indicated the facility used a contracted transportation company for transporting residents to and from medical appointments, but they did not use them for resident outings.	F 679		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to maintain an environment free of accident hazards for 1 of 5 residents (Resident #66) reviewed for supervision to prevent accidents. On 2/21/24, Resident #66 who was severely cognitively impaired with a	F 689	1.The facility failed to maintain an environment free of accident hazards for vulnerable residents by not maintaining a locked maintenance office door, located in hall of resident, enabling her to enter and obtain a knife. The Maintenance Director	5/8/24

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F 689	Continued From page 37 history of wandering was observed by Nursing Assistant (NA) #6 attempting to cut her cast off her left arm using a "long ridged knife with a handle." Resident #66 was unattended in the hallway outside of the maintenance room, the door was unlocked and partially open. NA #6 asked Resident #66 to hand her the "long ridged knife with handle" which she did with no issues, placed the knife back inside the maintenance room and shut the door without locking the door. The maintenance room was observed on 4/17/24 to be unlocked. This practice has a high likelihood that residents could access materials that could cause serious harm or injury. Immediate Jeopardy began on 2/21/24 when Resident #66 accessed a "long rigid knife with a handle" and was attempting to use it to cut her cast off. The immediate jeopardy was removed on 4/28/24 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. The findings included: Resident #66 was admitted to the facility on 2/16/24. Her admission diagnoses included fracture of left arm and dementia. Review of admission nursing progress note dated 02/16/24 read in part, Resident #66 history of dementia, alert and oriented to person, pleasantly confused and forgetful. Hospital diagnosis included fall with left wrist fracture with cast in	F 689	failed to manually lock the maintenance office door with a key upon exit on 2/21/24 and 4/17/24. The Administrator immediately informed the Maintenance Director who changed the lock out for a keypad security lock which allows door to lock automatically when shut on 4/17/24. 2. On 4/17/24 an audit of all doors to high-risk areas including kitchen entrance, shower rooms, housekeeping storage rooms was completed by the Administrator to ensure all had keypad security locks in place. 3. On 4/17/2024 the Administrator provided Maintenance Director with one-on-one education on the requirement for the facility to maintain an environment that is free of accident hazards by keeping all areas of the facility secure including housekeeping storage, kitchen entrance, and all other high-risk areas that residents have the potential to enter. In person education was completed by 4/24/2024 with all staff, including agency staff, by Director of Nursing (DON) on maintaining an environment free of accidents, hazards and that each resident receives adequate supervision and assistive devices to prevent accidents. Education included ensuring high risk areas of entry are secured at all times, halls are free of clutter. All new hires including maintenance staff and agency staff will be educated during the orientation process by DON/ ADON.	

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F 689	Continued From page 38 place." Resident #66's admission Minimum Data Set (MDS) assessment dated 2/22/24 revealed she was severely cognitively impaired. Resident #66 was also assessed as being ambulatory with assistance of a walker or wheelchair, wandering with the significant risk of getting to a potentially dangerous place. Review of admission care plan dated 2/22/24 revealed Resident #66 had an approach for wandering with a goal to reduce exit seeking behaviors. Interventions included wandering alarm bracelet located on Resident #66 left ankle, check wandering alarm bracelet every evening to ensure working properly, anticipate and meet resident needs in a prompt manner, notify MD and family of any changes in behavior, and monitor/ document/ report each shift and as needed any exit seeking behaviors or changes in behaviors. Review of facility incident report log for February 2024 revealed no incident reports for Resident #66. An interview with Nursing Assistant (NA) #6 on 4/17/24 at 9:00 AM revealed she had been employed at the facility since August 2023 and was familiar with Resident #66. She stated on 2/21/24 she was walking up the resident 200 hall and observed Resident #66 standing right outside of the maintenance room (located at the top of the 200 hall between the utility room and beauty parlor), the door was unlocked and cracked open with a "long ridged knife with a handle" in her right hand and using a back and forth motion was attempting to cut off the cast located on her left	F 689	4. Administrator/designee will perform audits 2x/week x12 weeks to ensure all high-risk areas of entry are secured and halls are free of clutter. Results of audits will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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arm. The NA stated she assumed Resident #66 had gotten the knife from inside the maintenance room since that was where she was standing. She revealed she asked Resident #66 to hand her the knife which she did with no issues, placed it back inside the maintenance room and shut the door, assessed Resident #66 body for any injuries, and walked her back to her room where she assessed her again for any injuries and did not observe any visible injuries and Resident #66 had no complaints of pain. NA #6 stated she did not recall if she informed any of the nurses on the hall but did report the incident to the DON. She revealed Resident #66 had a history of wandering all the halls in the facility and would stop at each room and try and turn all the door handles to see if they would open. She stated she had no knowledge of what occurred after she notified the DON of the incident, and she did not lock the maintenance door back and was not aware if anyone else locked the maintenance door after the incident or why the maintenance door had been unlocked in the first place.

An observation on 04/17/24 at 9:45 AM revealed a room door at the beginning of the resident 200 hall with no signage. The room was located between the utility room and the beauty salon. The door handle to the room had a keyhole on the front and lock on the back. After knocking on the door with no answer, the surveyor placed hand on the door handle to check if the door was locked and the door easily opened without the handle having to be turned. An observation of the inside of the room revealed access to tools such as a hammer, sharp screw drivers, screws and nails lying on the desk and in the floor, filing cabinets, computer system on the desk, a television propped against wall at the door, and

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papers lying on top of the desk and in the floor. The Regional Nursing Educator Consultant approached surveyor as the observation of maintenance room was being made from doorway and when asked about the incident stated she had no knowledge of the incident but that the door should be locked at all times to prevent residents from entering.

An interview was conducted with the Regional Maintenance Director on 04/17/24 at 10:40 AM revealed the previous Maintenance Director had left at the end of February 2024 and he had been filling the role since the first of March. He also revealed no knowledge of the incident with Resident #66 but stated the door to the room maintenance room should always be locked due to the tools and materials kept inside. He stated the maintenance room was used to store maintenance tools and equipment and to send and receive work orders from the computer located in the room. When asked if he was aware that the maintenance room door was currently unlocked, he stated he was not aware and that he had not been in the room on this date or the day prior and was not aware of how long the door had been unlocked. He revealed he had a key to the maintenance room door but was not aware of who else in the facility had access to the room and could have left it unlocked.

A telephone interview with the previous Maintenance Director on 4/17/24 at 11:47 AM revealed he had previously been employed with the facility in different roles but had worked as the Maintenance Director for several months prior to leaving at the end of February 2024. He stated he had no knowledge of the incident involving Resident #66 but was sure there had been times

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the maintenance room door could have been left unlocked and therefore residents could have had access to items in the room used for maintenance work such as knives or sharp tools. He revealed when he originally started as the Maintenance Director the room had a keypad lock but he would sometimes forget the code to unlock it so he changed the door lock to a regular door handle like the ones located on resident's rooms that could be locked from the inside and would require a key to open. The previous Maintenance Director stated he had a key to the lock but could not recall who else in the facility had a key and that the maintenance room door should have been locked at all times to prevent residents from entering the room.

An interview with the Administrator and DON on 4/18/24 at 12:20 PM revealed the Administrator had no knowledge of the incident with Resident #66 until yesterday and the DON stated she did not recall being informed by NA #6 of the incident either. They both revealed the maintenance door should have been locked at all times to prevent residents and other staff from having access to the room and staff should have reported the incident immediately and documented the details of the incident.

The Administrator was notified of immediate jeopardy on 4/26/24 at 11:02 AM.

The facility provided the following plan for immediate jeopardy (IJ) removal.

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

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The facility failed to maintain an environment free of accident hazards for vulnerable residents by not maintaining locked maintenance office door, located in hall of resident, enabling her to enter and obtain the knife. On 2/21/24 Resident #66 was observed by Nurse Aide (NA) #6 to have a ridged knife in her hand attempting to cut off her cast. NA #6 removed knife from resident, secured maintenance door. NA #6 did not note any injuries or cuts on the cast.

Administration was not aware of the incident with Resident #66 that occurred on 2/21/24 until 4/17/24.

The physician or family wasn't made aware of the incident that occurred with Resident #66 on 2/21/24.

Resident #66 cast was removed on 3/20/24.

Resident #66 discharged from the facility on 4/23/24.

On 4/17/24 the maintenance office door was observed unlocked by a member of the survey team and notified the Regional Nurse. The Regional Nurse immediately notified the Administrator that the door was unlocked. The Administrator immediately informed the Maintenance Director who changed the lock out for a keypad security lock which allows door to lock automatically when shut on 4/17/24.

The root cause analysis determined that the Maintenance Director failed to manually lock the maintenance office door with a key upon exit on 2/21/24 and 4/17/24.

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F 689	Continued From page 43 On 4/17/2024 the Administrator provided Maintenance Director with one-on-one education on the requirement for the facility to maintain an environment that is free of accident hazards by keeping all areas of the facility secure including housekeeping storage, kitchen entrance, and all other high-risk areas that residents have the potential to enter. All residents residing in the facility can be affected by the deficient practice. On 4/17/24 an audit of all doors to high-risk areas including kitchen entrance, shower rooms, housekeeping storage rooms was completed by the Administrator to ensure all had keypad security locks in place. On 4/17/24 administrative staff were instructed by the Administrator to monitor and ensure all high-risk areas of entry are secured and halls are free of clutter. Any issues identified will be corrected and reported to the Administrator immediately. On 4/27/24 the Administrator, DON and the Maintenance Director met to identify any high-risk areas in the facility and reviewed accidents/incidents including resident falls, injuries, and resident transportation back to April 1, 2024, to determine if there were any that were avoidable accidents or incidents. The review of the accidents/incidents did not determine the need for further analysis, education, or monitoring. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.	F 689		

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F 689	Continued From page 44 On 4/23/24, a QAPI meeting was held with all facility department heads at which time all were educated on potential accidents and hazards related to residents accessing hazardous materials and requirement for these items to be secure at all times by the Administrator. On 4/24/24 in person education began with all staff, including agency staff, by Director of Nursing (DON) on maintaining an environment free of accidents, hazards and that each resident receives adequate supervision and assistive devices to prevent accidents. Education included ensuring high risk areas of entry are secured at all times, halls are free of clutter. All staff not educated on 4/24/24 will be educated by DON or Assistant Director of Nursing (ADON prior to the start of their next shift. The Administrator will be responsible for maintaining employee log to identify staff that may still require education. Upon review of staff log, the Administrator will notify DON/ADON of any staff requiring education. All new hires, including maintenance staff and agency staff will be educated during the orientation process by DON/ ADON. The DON and ADON were made aware of this responsibility on 4/24/24 by the Administrator. Alleged date of immediate jeopardy removal: date 4/28/24 A validation of immediate jeopardy removal was conducted on 05/07/24. The maintenance office door was noted to be closed, locked, and secured on 05/07/24 along with the other doors in the facility that potentially had hazardous chemicals or equipment in them. The doors include the spa doors located on each hallway, the maintenance office door, the kitchen doors, the supply room,	F 689		

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F 689	Continued From page 45 the oxygen storage room, the housekeeping closet, and any other ancillary room that was identified by the facility, all were locked and secured. Interviews with administrative staff revealed that they had been educated on the need for continued monitoring of the doors to ensure that they were locked and secured to ensure resident safety. In-service records and interviews with all staff across all departments revealed that they had been educated on ensuring resident safety by keeping hallways clutter free and ensuring doors to potentially hazardous areas, chemicals, and equipment were always secure and if not to ensure no resident was in the area, secure the area and notify the administrator. The facility's QA committee met on 04/23/24 and conducted a root cause analysis which was reviewed as part of the removal process. Audits conducted daily from 04/17/24 through 05/07/24 were reviewed with no issues. The facility's removal date of 04/28/24 was validated.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to stop wound care when Resident #1 complained of pain of a 7 on a scale of 1-10 and address her pain before finishing the wound care for 1 of 1	F 697	1. Based on observations, record review, resident, and staff interviews the facility failed to stop wound care when Resident #1 complained of pain of a 7 on a scale of 1-10 and address her pain before finishing	5/17/24

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F 697	Continued From page 46 residents reviewed for pain. The findings included: Resident #1 was admitted to the facility on 06/18/21 and most recently readmitted on 01/02/24. Resident #1's diagnoses included pressure ulcer of right hip and chronic pain syndrome. A physician's order dated 01/10/24 read, Acetaminophen-Codeine Orla 300-30 give one tablet by mouth every 6 hours as needed for pain related to chronic pain syndrome not to exceed 3 grams (gm) of acetaminophen in a 24-hour period. Review of a physician's order dated 01/10/24 read, Acetaminophen 325 milligrams (mg) give 2 tablets by mouth every 6 hours as needed for pain not to exceed 3 grams of acetaminophen in a 24-hour period. The significant change Minimum Data Set (MDS) dated 03/21/24 revealed that Resident #1 was moderately cognitively impaired and had one unstageable pressure ulcer that was not present on admission. The MDS also indicated that Resident #1 received pressure ulcer care during the assessment reference period and had taken an opioid medication. A pain care plan that was revised on 03/25/24 read; the resident has chronic pain related to mobility and aging process. The goal read; the resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The interventions included administer analgesia as ordered,	F 697	the wound care for 1 of 1residents reviewed for pain. On 4/17/24, residents received as needed pain medication at 3:47pm. On 5/9/24 an order was obtained by physician to give pain medication prior to wound care treatments as needed. 2. By 5/16/2024 an audit was conducted by Director of Nursing/Assistant Director of Nursing (DON/ADON) on all residents who require wound care. Orders were obtained and added to medication administration record to give pain medication prior to wound care treatments as needed by DON/ADON. 3. On 4/18/2024 DON/ADON re-educated Nurse #8 and Nurse #9 on the requirement that the facility must ensure that pain management is provided that alleviates the residents pain to a level that is acceptable to the resident, including assessing the potential for pain, effectively recognizing the presence of pain and modifying or stopping treatments if the resident complains of pain. On 4/24/24 All licensed nurses, including agency staff were re-educated by the DON/ADON. All newly hired licensed nurses and new agency staff nurses will be educated during orientation process by DON/ADON. 4. Random interviews will be conducted by DON/designee 2x/week x12 weeks with residents who require wound care to ensure pain was at an acceptable level during treatment. Observations of wound care to assess for signs and symptoms of pain will be conducted for those residents	

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F 697	Continued From page 47 anticipate the residents needs for pain relief and respond immediately to any complaint of pain, evaluate the effectiveness of pain interventions, monitor and report loss of appetite, monitor and report to nurse complaints of pain, notify physician if interventions are unsuccessful, and observe and report changes in sleep pattern. Review of the Medication Administration Record (MAR) dated April 2024 revealed that on 04/17/24 Resident #1 had received Acetaminophen-Codeine Orla 300-30 at 9:49 AM for pain in her back that was rated a 6 on a pain scale of 1-10. Further review of the MAR revealed that on 04/17/24 Resident #1 received Acetaminophen 325 mg 2 tablets by mouth at 3:47 PM for a headache that was rated a 3 on pain scale of 1-10. An observation of wound care was conducted on 04/17/24 at 2:46 PM with Nurse #8 and Nurse #9. Nurse #9 was observed to transfer Resident #1 from her wheelchair to her bed and while Nurse #8 stood next to Resident #1, Nurse #9 washed and dried her hands and donned clean gloves. Nurse #9 was observed to remove a dirty dressing from Resident #1's mid chest and clean the wound with wound cleaner and then doffed her gloves, washed her hands, and again donned clean gloves. Resident #1 was then asked to turn onto her left side and once her pants were pulled down there was dressing noted to her right hip that was dated 04/16/24, Nurse #9 removed the old dressing and discarded it then cleaned the wound on the right hip with wound cleaner. She removed her gloves and washed her hands and donned clean gloves. Resident #1 then stated	F 697	who are not able to be interviewed. Results of audits will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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that she was hurting "right there on that spot" referring to the wound on her right hip. When asked what level her pain was, she replied "it is a 7." Nurse #9 stated that she would get her something for pain as soon as she was done with wound care. Nurse #9 applied zinc oxide as prescribed to the peri wound, and Resident #1 stated "that hurt." Nurse #9 gently laid a piece of medi-honey (honed soaked dressing) on top of the wound and covered the wound with adhesive dressing. Nurse #9 then removed her gloves and washed her hands again. While still resting in bed Resident #1 again stated that she hurt in her right hip and her head. Nurse #8 and Nurse #9 transferred Resident #1 to her wheelchair before exiting her room. Resident #1 was not crying and did not appear anxious at the time of the wound care. Nurse #9 asked her if she wanted something for pain and Resident #1 stated "yes."

Nurse #9 was interviewed on 04/17/24 at 3:04 PM, she stated Resident #1 had never complained of pain during wound care before. She explained that she was usually anxious and wanted something for her nerves but had not complained of pain. Nurse #9 reviewed Resident #1's medical record and stated that she had Acetaminophen-Codeine at 9:49 AM and it would not be due again until 3:49 PM. Nurse #9 stated if Resident #1 had been complaining of pain directly on the wound she would have gone and asked the nurse for pain medication. Nurse #9 added that all residents were asked about pain every shift and if they reported pain, they were given something for their pain. Nurse #9 added that if Resident #1 was in pain she would tell me but most of the time she reported being anxious.

A follow up interview with Nurse #8 and Nurse #9

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F 697	Continued From page 49 was conducted on 04/17/24 at 3:39 PM. Both Nurse #8 and Nurse #9 confirmed that Resident #1 complained of pain in her right hip that was a 7 on a pain scale and also complained of pain in her head. The Administrator was interviewed on 04/18/24 at 12:00 PM. The Administrator stated wound care should have been stopped and Resident #1's pain addressed. The Director of Nursing (DON) was interviewed on 04/18/24 at 2:49 PM who stated, pain was subjective and when a resident complains of pain "we handle it." The staff assessed pain every shift and as needed. When Resident #1 complained of pain during wound care, the staff should have stopped the wound care and completed a full pain assessment and if she had nothing that could be given for pain the medial provider should have contacted.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide breakfast, a bagged meal or snack for 2 of 2 residents (Resident #20 and #21) reviewed for dialysis. The findings included:	F 698	1. Based on record review, resident and staff interviews the facility failed to provide breakfast, a bagged meal or snack for 2 of 2 residents (Resident #20 and #21) reviewed for dialysis. All residents who were identified as having not received a	5/17/24

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F 698	Continued From page 50 a. Resident #20 was admitted to the facility on 1/16/18 with diagnosis including type 2 diabetes and end stage renal disease. A quarterly Minimum Data Set (MDS) dated 2/03/24 indicated Resident #20 was cognitively intact. An interview with Resident #20 on 4/15/24 at 4:00 PM revealed she did not always receive a meal when she went to dialysis and would have to wait until she returned from her treatments around lunch time before she was able to eat. She stated she attended dialysis three times a week from 5:30 AM to 10:30 AM and the facility was supposed to provide her with a bagged lunch that contained a sandwich, snacks, and drink but for the past several months she had not received her bagged lunch, or it would be missing the sandwich and drink. She stated this past weekend the Administrator had to bring the bagged lunched to the facility because they were not available when they left for their treatments. Resident #20 stated that she would like to have her bagged meal with her at dialysis so that she can have a little something to eat and to have in case her blood sugars were ever to drop while receiving her treatments. b. Resident #21 was admitted to the facility on 7/13/23 with diagnosis including type 2 diabetes and end stage renal disease. A quarterly MDS dated 1/14/24 indicated Resident #21 was cognitively intact.	F 698	bagged lunch prior to leaving for dialysis, were supplied one or had food ordered to dialysis center by Administrator. 2. All residents who attend dialysis have the potential to be affected by deficient practice. Starting on 4/18/2024, dietary staff to ensure a breakfast, bagged meal, or snack is prepared for all dialysis residents and stored in an accessible location for nursing staff to send with residents on treatment days. 3. All dietary and nursing staff were educated by 5/16/2024 by the Administrator/designee on the importance of dialysis residents having their bagged meals with them during their treatments and designated storage location. All newly hired staff will be educated by DON/Designee during the orientation process. 4. Administrator/designee will conduct audit 2x/week x12 weeks to ensure bagged meals or snacks are prepared and available to send with dialysis residents on treatment days. Results of audits will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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An interview with Resident #21 on 4/15/24 at 11:21 AM revealed he did not always receive a meal when he went to dialysis and would have to wait until lunch time before he could eat. Resident #21 reported he attended dialysis three times a week from 5:30 AM to 10:30 AM and the facility was supposed to provide him with a bagged meal he could take with him that should contain a sandwich, snacks and a drink. He stated for the past several months he either not received his bagged meal when leaving for dialysis, the bagged meal has missing items such as no sandwich and no drink, or the Administrator has had to bring them their bagged meal to the dialysis facility. Resident #21 stated although he had not suffered from any low blood sugar from missing out on his bagged meal, he still gets hungry and would like to have his bagged meal or at least a snack to take with him.

An interview with Dietary Manager (DM) #1 on 04/16/24 at 2:15 PM revealed she had been employed at the facility for about a month and when she came there were issues with the dialysis bags (sandwich/2 snacks/ drink) not being available for residents in nourishment rooms for the residents that leave early and nursing staff not being able to access them in kitchen or dietary staff not fixing them for the next morning. She stated dietary staff are responsible for preparing and labeling the bagged meals the night before and placing them in the nourishment room for the dialysis residents who leave the facility prior to breakfast being served. DM #1 revealed she was not aware there had not been any bagged meals left for dialysis residents over the past weekend until yesterday, so she made sure all dietary staff were educated on making sure the dialysis bagged meals were prepared

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and labeled each night and placed in the nourishment room.

An interview with the Nutritional Manager on 04/16/24 at 3:16 PM revealed no knowledge of dialysis residents who leave the facility prior to receiving breakfast not receiving their bagged meals to take with them to treatment. She stated dietary staff should be preparing those bagged meals each evening and placing them in the nourishment room where they are available for staff to give to dialysis residents prior to them leaving. She revealed the bagged meals are provided to dialysis residents due to them leaving prior to breakfast being served and also to provide them with some nutrition to prevent low blood sugar or nausea.

An interview with Nursing Assistant (NA) #6 on 04/17/24 at 9:05 AM revealed she had worked at facility since August 2023 both 1st and 2nd shift and was familiar with dialysis residents bagged meals not being available for those that leave early in the mornings. She stated dietary staff were not preparing the bagged meals and leaving them in the nourishment room and nursing staff were unable to access the kitchen to be able to receive or prepare the bagged meal. She revealed that she had seen an improvement over the past week or so with dietary staff preparing and labeling bagged meals and placing them in the nourishment rooms.

An interview with Unit Manager #1 on 04/17/24 at 5:40 PM revealed there had been past issues with dialysis residents who leave prior to breakfast not receiving their bagged meals to take with them due to dietary staff not preparing the meals or nursing staff not having access to

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F 698	Continued From page 53 the kitchen to receive the bagged meals. She stated recently dietary and nursing staff were educated on the importance of dietary residents receiving their bagged meals prior to their treatments and she felt like the issue had improved and to her knowledge there had been no further issues. An interview with the Administrator on 4/18/24 at 4:45 PM revealed she expected the bagged meals for dialysis residents to be prepared and labeled the prior evening, so they were accessible to those residents who leave prior to breakfast being served. The Administrator further revealed she was aware of issues with the bagged meals not being prepared prior to dialysis residents leaving for their treatment and she has had to wait on dietary staff to prepare the bagged meals and deliver them to the dialysis facility herself. The Administrator stated dietary and nursing staff have been educated on the importance of dialysis residents having their bagged meals with them during their treatments to help prevent side effects such as low blood sugar or nausea.	F 698		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Medical Doctor (MD) interview the facility failed to prevent a significant medication error by failing to administer morning medications for a dialysis resident (Resident #20) for 1 of 3 residents reviewed for assuring the facility was free of	F 760	1.The facility failed to prevent significant medication errors when Resident #20 was not administered medications as ordered by the physician prescribed to treat diabetes, epilepsy and hypertensive heart disease and chronic kidney disease with	5/8/24

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medication errors. Resident #20 attended dialysis treatments on Tuesday, Thursday, and Saturday from 5:30 AM to 10:30 AM and was not administered her significant morning medications. Per the manufacturer label warnings, failure to administer these medications could have resulted in non-therapeutic levels resulting in seizure activity, high blood sugars which could lead to diabetic coma, and increased blood pressure and heart rate which could lead to stroke and cardiac complications.

Immediate jeopardy began on 04/02/24 when the facility failed to administer Resident #20's morning medications. Immediate jeopardy was removed on 04/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put into place are effective.

The findings included:

Resident #20 was admitted to the facility on 01/16/18. Resident #20's diagnoses included dependence on renal dialysis, seizures, type 2 diabetes, depression, chronic kidney and heart failure.

Review of quarterly Minimum Data Set (MDS) dated 02/03/24 revealed Resident #20 was cognitively intact and was assessed for receiving dialysis treatments.

Review of current physician order revealed heart failure, and depression. On 4/18/24 facility Medical Director (MD) was notified by the Director of Nursing (DON) of Resident #20□s identified medication errors. Nurse Practitioner assessed Resident #20 on 4/18/24. No new orders were received.

2. On 4/26/24 DON audited all current residents□ Medication Administration Records back to 4/1/24 for any potential significant medication errors including missed/omitted medications or those marked as leave of absence. No additional significant medication errors were noted. An order was obtained from the MD for specific medication administration guidelines for all residents in the facility who receive dialysis services.

3. On 4/18/24 Nurse #13 received verbal 1 on 1 education by Director of Nursing (DON) on 6 rights of medication administration, potential adverse effects of missed medications, documentation requirements regarding omissions, significant medication errors, and administering medications upon resident return from dialysis. Education to all licensed nurses, medication aides, and nurse #15 was completed by DON by 4/26/24. All newly hired nurses and medication aides, including agency nurses and medication aides, will receive this education from the DON/Designee during the orientation process.

4. DON/ADON/Designee will complete

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F 760	Continued From page 55 Resident #20 was to receive scheduled dialysis treatments outside of facility every Tuesday, Thursday, and Saturday. Pick up time at 5:30 AM from the facility. Review of physician orders for significant medication for Resident #20 are as follows: Escitalopram Oxalate Tablet 20 milligrams (MG), give 1 tablet by mouth one time a day for depression related to MAJOR DEPRESSIVE DISORDER Keppra XR Oral Tablet Extended Release 24 Hour 500 MG (Levetiracetam), give 1 tablet by mouth one time a day related to EPILEPSY Ozempic (1 MG/DOSE) Subcutaneous Solution Pen-injector 4 MG/3 milliliter (ML) (Semaglutide) Inject 1 mg subcutaneously (beneath skin) one time a day every Thu related to TYPE 2 DIABETES Carvedilol Oral Tablet 25 MG (Carvedilol), give 1 tablet by mouth two times a day related to HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE WITH HEART FAILURE HumaLOG KwikPen 100 UNIT/ML Solution pen-injector Inject as per sliding scale: if 0 - 150 = 0 Units Notify Provider if less than 60; 151 - 200 = 2 Units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units; 401+ = 12 Units Notify provider if greater than 401, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (high blood sugars). Review of Medication Administration Record	F 760	audit 2x/week x12 weeks for medication omissions and medication errors. Results of audits will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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dated April 2024 revealed dates of Resident #20 not receiving significant morning medications due to being out of the facility for scheduled dialysis treatments. Nursing staff coded reason for not administering medications as #3 (resident on leave of absence). Per Resident #20 April 2024 MAR, missed doses of scheduled significant morning medication are as follows:

Escitalopram (9 AM) - Tuesday 4/02 (Nurse #13), Thursday 4/11 (Nurse #13), Tuesday 4/16 (Nurse #15)
Keppra (8 AM) - Tuesday 4/02 (Nurse #13), Tuesday 4/09 (Nurse #13), Thursday 4/11 (Nurse #13), Tuesday 4/16 (Nurse #15)
Ozempic (9 AM) - Thursday 4/11 (Nurse #13)
Carvedilol (7:30 AM) - Tuesday 4/02 (Nurse #13), Tuesday 4/09 (Nurse #13), Thursday 4/11 (Nurse #13), Tuesday 4/16 (Nurse #15)
Humalog and blood sugars (7:30 AM) - Tuesday 4/02 (Nurse #13), Tuesday 4/09 (Nurse #13), Thursday 4/11 (Nurse #13), Tuesday 4/16 (Nurse #15)

Review of Resident #20 progress notes for April 2024 revealed blood pressure and blood sugar were within normal limits.

An interview was conducted with Resident #20 on 04/16/24 at 4:54 PM revealed she had missed her morning medications on several occasions and although she could not recall the exact dates of when they were missed, she stated it usually occurred on the days she received her dialysis treatments. She stated to her knowledge she had not had any issues with her blood sugars or seizures from missing the medications but would like to receive her medications as ordered so that doesn't happen. She revealed she attends her

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dialysis treatments 3 days a week and leaves the facility at 5:30 AM and returns at 10:30 AM and sometimes nursing staff will give her medications to her with food when she returns and other times they don't. Resident #20 stated she had asked about not receiving her medications before and staff would tell her they could only be given at their scheduled time. She revealed she had not told anyone such as the Administrator or Director of Nursing (DON) about the missing medications.

A telephone interview was conducted with Nurse #15 on 04/18/24 at 12:20 PM revealed for the past several months she had worked both 1st and 2nd shift at the facility as an agency nurse and was typically assigned to work the medication carts on the resident halls. She stated she believed Resident #20 received dialysis treatments and on the days she received treatments she would leave the facility around 5 AM and return around 10:30 AM. Nurse #15 verified her initials listed for the MAR, the dates that she worked the medication cart for Resident #20 hall and on the dates Resident #20 had been at dialysis she was not able to administer her morning medications and did not administer them when she returned. She stated she was not aware that she was supposed to hold resident medications and wait to administer when they arrived back from dialysis and had coded the reason for not administering the medications as resident leave of absence because she did not know what other code to use for a resident out of facility for a treatment. She revealed she did not recall if Resident #20 asked about not receiving her medications.

An interview was conducted with Nurse #13 on 4/18/24 at 2:35 PM revealed for the past several

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months she had worked 1st shift at the facility as an agency nurse and was typically assigned to work the medication carts on resident halls. She stated she was familiar with Resident #20 and had administered her medications on several occasions. She also stated that Resident #20 received dialysis treatments 3x's a week and was usually gone for her treatments before she came into work and would return from them around 10:30 AM. Nurse #13 verified her initials listed for the MAR, the dates that she had worked the medication cart for Resident #20 hall. She admitted she had not administered Resident #20 her morning medications on the dates she had coded as resident leave of absence and was not aware that she was supposed to administer those medications when Resident #20 arrived back from treatments. She revealed she did not recall if Resident #20 asked about not receiving her medications.

A telephone interview was conducted with the MD on 04/17/24 at 4:24 PM. The MD revealed that he had not been made aware of Resident #20 not receiving her morning medications on the days she received dialysis. He stated all dialysis residents should be administered any medications missed while at dialysis upon their return. The MD also stated that he would expect to notify him if resident dialysis treatments were conflicting with when a medication was ordered to be administered so he could adjust the medications and their times to be administered. Due to having no knowledge of Resident #20 not being administered morning medications on days where she had received dialysis treatments, he was not able to comment on any outcome it caused or could have caused and whether those would have been significant or not.

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An interview was conducted with the Administrator and Director of Nursing (DON) on 04/18/24 at 12:20 PM revealed they were not aware Resident #20 had missed her medications. The Administrator stated nursing staff had been educated that anytime a medication is not administered to a resident for whatever reason they were to notify the supervisor and document. The Administrator and DON revealed all dialysis residents should be administered their scheduled medications and any issues with not being able to administer those medications should be reported to the nursing supervisor immediately, the MD, and documented.

The Administrator was notified of immediate jeopardy on 04/26/24 at 1:07 PM.

The facility provided the following plan for IJ removal.

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

The facility failed to prevent significant medication errors when Resident #20 was not administered medications as ordered by the physician prescribed to treat diabetes, epilepsy and hypertensive heart disease and chronic kidney disease with heart failure, and depression. Nurse #13 and Nurse #15 did not administer Resident #20 her morning medications when she returned to the facility from her dialysis treatments.

On 4/18/24 facility Medical Director (MD) was notified by the Director of Nursing (DON) of

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Resident #20's identified medication errors. An order was obtained from the MD to administer all prescribed medications upon return from dialysis for all residents in the facility who receive dialysis services. These orders were added to each resident's Medication Administration Record by Assistant Director of Nursing (ADON) on 4/18/24. On 4/18/24 Dialysis residents care plans were updated MDS Coordinator.

Nurse Practitioner assessed Resident #20 on 4/18/24. No new orders were received.
On 4/18/24 Nurse #13 received verbal 1 on 1 education by Director of Nursing (DON) on 6 rights of medication administration, potential adverse effects of missed medications, documentation requirements regarding omissions, significant medication errors, and administering medications upon resident return from dialysis. Nurse #13 verbalized understanding of re-education.
4/26/24 DON audited all current residents' Medication Administration Records back to 4/1/24 for any potential significant medication errors including missed/omitted medications or those marked as leave of absence. No additional significant medication errors were noted.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 4/24/24 a Quality Assurance Performance Improvement (QAPI) meeting was held by the Administrator (LNHA) with all department heads and MD via phone regarding identification of the significant medication error.
Education/audits/monitoring were discussed.

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Department Heads and MD verbalized understanding of education, audits and ongoing monitoring.

On 4/24/24 in person education began with all licensed nurses (including Nurse #15) and medication aides, including agency nurses or med aides, by DON/ Assistant Director of Nursing (ADON)/Nurse Managers on 6 rights of medication administration, potential adverse effects of missed medications, documentation requirements regarding omissions, significant medication errors, and administering medications upon resident return from dialysis or leave of absence. All staff verbalized understanding. Education to all remaining licensed nurses and medication aides was completed by DON on 4/26/24 via phone and/or in person. All newly hired nurses and medication aides, including agency nurses and medication aides, will receive this education from the DON/ADON during the orientation process. Nurse Manager on duty will provide verbal education to any agency staff member that works after 4/26/24 prior to accepting shift assignment. The Nurse Managers were notified of this responsibility on 4/24/24. The DON will notify the Nurse Managers when there is a new agency nurse or medication aide that requires the education.

Alleged date of immediate jeopardy removal: 4/27/24

A validation of immediate jeopardy removal was conducted on 05/07/24. The audit of all dialysis residents was reviewed and verified that each resident that received dialysis had an ordered entered into their medical record that indicated all prescribed medications were to be given upon

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F 760	Continued From page 62 return from dialysis treatment. Each resident's care plan was also updated and verified as a part of the removal verification process. Staff in-service records and interviews with nursing staff confirmed they were educated on the requirement of notification to the medical provider and responsible party when medications were missed or omitted. The facility's QA committee met on 04/24/24 and reviewed the policy on notification which did not require any revisions. The QA verbalized understanding of the policy and requirement. Audits completed from 04/28/24 through 05/06/24 were reviewed with no new issues identified. The facility's removal date of 04/27/24 was validated.	F 760		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced	F 802		5/8/24

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F 802	Continued From page 63 by: Based on observations, record review and staff interview the facility failed to verify Cook #1's competencies and certifications for food production and meal service prior to first day of employment. The findings included: An interview on 04/16/24 at 02:05 PM with Dietary Manager (DM) #1 revealed new employees should be signed off on competencies before they are left on their own to work. DM #1 explained the kitchen had a checklist of competencies for the cook/chef staff, but DM #1 stated Cook #1 was assigned to another staff member for training on his first day (4/15/24). DM #1 revealed that she thought DM #2 from another facility was training Cook #1 that day (4/16/24) and she was not aware that DM #2 was not told that she was responsible for training Cook #1. DM #1 stated she should have ensured that DM #2 knew she was responsible for training Cook #1 on 04/16/24. DM #2 was not given Cook #1's checklist on 04/16/24. DM #1 reported that Cook #1 had not received food temperature training yet because that training was done on the second day. DM #1 reported she was responsible for the hiring process in the kitchen and reported she interviewed Cook #1 and took him at his word he had Servsafe certification (certificate proving completion of program to handle and serve food in a safe manner to prevent foodborne diseases), and culinary school training. During an interview on 04/17/24 at 2:43 PM DM #1 stated she had to call Cook #1 on 04/17/24 and request that he call back so they could get copies of his Servsafe certification and culinary	F 802	1. Based on our observations, record review and staff interview, the facility failed to verify Cook #1 competencies and certification for food production and meal service prior to the first day of employment. On 4/20/2024 cook #1 completed his competency training. 2. An audit was conducted on 4/18/24 of all cook files to ensure that they had competency completed. All discrepancies were corrected by the Regional Operations Manager by 4/25/24. 3. Re-Education was conducted by the Regional Operations Manager on 4/18/24 with the dietary manager to include: Cooks must have competency completed prior to being on food production line independently. All newly hired Dietary Managers will be educated during orientation by Regional Operations Manager. 4. The Regional Operations Manager will audit 3 employee files monthly x 3 months to ensure competencies are completed. The results of the audits will be reported to the Quality Assurance committee by the Dietary Manger or Administrator monthly for three months.	

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degree. DM #1 stated she should have verified his certifications before hire.

An interview on 04/16/24 at 02:40 PM with Cook #1 revealed he had not had any training from the facility, and no one was training him on 04/16/24 because they were short, so he just jumped in and went to prepare food. Cook #1 confirmed his first day at the facility was 04/15/24. Cook #1 stated he had completed the ServSafe certification and course and had gone to culinary school. Cook #1 confirmed no one asked him for certificates at the time of hire. Cook #1 revealed that he provided his Servsafe certificate to the Regional Director of Operations (RDO) for Dietary for the food service provider on 04/18/24 after she called and asked him to produce the certificate.

A review of Cook #1's competency checklist revealed at the top of the sheet there was a start date for evaluation, and it was dated 04/14/2024 and then a line that stated completion date of evaluation period of 04/15/24 even though all competencies below had not been completed. A review of the competency checklist revealed that cooking food temps were dated as completed on 04/15/24 for poultry, stuffed food, ground meat, fish, and other meats. All these food temps' categories were dated 04/14/24 and were signed off by DM #1.

During an interview on 04/18/24 at 10:58 AM the Regional Director of Operations (RDO) for Dietary provided a Servsafe certification for Cook #1 with expiration date of 10/27/26 and a copy of a screen shot dated 2013 that Cook #1 had been accepted to culinary school but was unable to verify completion. She also produced Cook #1's

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F 802	Continued From page 65 competencies for training for a cook/chef which were dated 04/14/2024 and 04/15/2024 and signed off by Dietary Manager #1. The RDO stated that the DM #1 was responsible for the hiring process for the kitchen staff, and she was not involved in the hiring for individual buildings. The RDO stated that the DM #1 was responsible for verifying competencies and certification for any new staff hired to the department,	F 802		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews the facility failed to provide evening snacks to residents when requested for 4 of 4 residents (Resident #9, #20, #21, and #171)	F 809	1. Based on our observations, resident and staff interviews, the facility failed to provide evening snacks to residents when requested for resident #9, #21, and #171	5/17/24

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F 809	Continued From page 66 reviewed for frequency of snacks. This practice had the potential to affect other residents who requested evening snacks. The findings included: a. Resident #9 was admitted to the facility on 5/24/22 with diagnosis that included type 2 diabetes and heart failure. A quarterly Minimum Data Set (MDS) dated 3/05/24 indicated Resident #9 was cognitively intact. An interview with Resident #9 on 4/15/24 at 4:31 PM revealed since he had been at the facility he might have received an evening snack maybe once or twice but not on a consistent basis. He stated he did not have the money to be able to purchase his own snacks all of the time and felt the facility should be able to provide him with an evening snack when requested. Resident #9 revealed when he would ask staff about receiving an evening snack, they would tell him there were no snacks available in the nourishment room for them to give to him and they did not have access to get snacks from the kitchen. b. Resident # 171 was admitted to the facility on 4/22/23 and discharged on 9/16/23. She was cognitively intact with diagnosis that included type 2 diabetes and congestive heart failure. A quarterly MDS dated 7/22/23 indicated Resident #171 was cognitively intact. A telephone interview with Resident #171 on 4/15/24 at 4:31 PM revealed during her stay at the facility she might have received an evening	F 809	reviewed for frequency of snacks. On 4/19/24 all residents, which would include resident #9, #21 and #171 they were in-house received a snack. 2. All residents in the facility have the potential to be affected by this deficient practice. On 4/19/24 interviews were conducted by the Administrator with residents regarding receiving evening snacks. All residents responded they would like to be offered a snack at night. All residents except those with an order for nothing by mouth will be offered an evening snack. 3. Re-Education was completed by 5/16/24 by the Director of Nursing and Administrator on with the nursing staff and dietary staff to ensure enough snacks are available and all residents were offered and received a snack if they desired one. All newly hired nursing staff and dietary staff will be educated during orientation by ADON/dietary manager/designee. 4. The Administrator or Director of Nursing will interview 5 residents 3x per week for 12 weeks for offering and receipt of snacks. The results of the audits will be reported to the QA committee by the Administrator or Director of Nursing monthly for three months.	

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snack maybe once or twice but not on a consistent basis. She stated she would have her sister bring her snacks or buy them herself. Resident #171 revealed when she would ask staff about receiving an evening snack, they would tell her there were no snacks available for them to give to her.

c. Resident #20 was admitted to the facility on 1/16/18 with diagnosis that included type 2 diabetes and end stage renal disease.

A quarterly MDS dated 2/03/24 indicated Resident #20 was cognitively intact.

An interview with Resident #20 on 4/15/24 at 4:00 PM revealed during her stay at the facility she had never received an evening snack on a consistent basis. She stated when she has requested an evening snack from nursing staff, they have told her that there were no snacks available or all of them were passed on another hall and they had ran out for the evening and did not have access to the kitchen to refill their snacks.

d. Resident #21 was admitted to the facility on 7/13/23 with diagnosis that included type 2 diabetes and end stage renal disease.

A quarterly MDS dated 1/14/24 indicated Resident #21 was cognitively intact.

An interview with Resident#21 on 4/15/24 at 11:21 AM revealed since he had been at the facility he had never received an evening snack or been offered an evening snack consistently. He stated sometimes nursing staff will ask if you

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F 809	Continued From page 68	F 809		

want a snack and other times you have to request it and when you do the staff will usually come back and say they couldn't find any snacks in the nourishment room and they were not able to access the kitchen for more snacks.

An observation of nourishment room on 04/15/24 at 03:05 PM with Unit Manager #1 revealed the refrigerator to be empty except for two thickened liquid juices. There were five bagged snacks and two snack cakes located in the cabinet of the room. When the Unit Manager #1 was asked about why there were no snacks, sandwiches, or drinks available in the nourishment rooms she stated dietary staff were supposed to stock the nourishment rooms daily and she was not aware until now of there not being any snacks or drinks available.

An interview with Dietary Manager #1 on 04/16/24 at 2:15 PM revealed been here for about a month and was aware of issues with no snacks being available in the nourishment rooms for residents and nursing staff not having access to snacks from the kitchen. She stated she was not aware until yesterday of dietary staff not stocking the nourishment room, so she stocked the nourishment room herself last night and informed nursing staff that it had been stocked and was available for residents. She also stated she had educated dietary staff on making sure the nourishment room was stocked with snacks, sandwiches, and drinks to be available for residents and staff.

An interview with Nursing Assistant (NA) #6 on 04/17/24 at 9:05 AM revealed she had worked at facility since August 2023 both 1st and 2nd shift and was familiar with resident complaints of not

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F 809	Continued From page 69 receiving their evening snacks. She stated there have been times when she has gone to the nourishment room and there were no snacks available, no sandwiches, and no drinks and she informed dietary staff of the issue. NA #6 stated recently there have been more snacks available and residents are able to receive their evening snacks when requested. An interview with the Administrator on 4/18/24 at 4:45 PM revealed she expected there to always be snacks available for residents. The Administrator further revealed dietary staff should be stocking enough snacks, sandwiches, and drinks for residents and nursing staff should have notified dietary staff, nursing supervisors, the DON or herself if there was an issue with not having evening snacks available for residents. The Administrator indicated nursing staff could have asked the Director of Nursing or Unit Managers for the codes to the nourishment rooms. She stated that she orders an overabundance of snacks each month to make sure residents have a variety of options for their snacks and there was no reason why residents should not be receiving their evening snacks.	F 809		
F 812 SS=K	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		5/8/24

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F 812	Continued From page 70 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff, resident, Registered Dietitian, and Food Service Provider Representative interviews the facility failed to ensure that fried chicken was completely cooked before serving to residents on lunch trays by 1 of 2 cooks (Cook #1). Undercooked fried chicken was served to 15 of 69 residents and 5 of 15 residents consumed the undercooked fried chicken. Resident #54, Resident #21, Resident #37, Resident #51, and Resident #45 were noted as having consumed the undercooked fried chicken. This unsafe food handling practice had a high likelihood for food borne illness for residents. In addition, the facility failed to have food items labeled with a use by or expiration date and discard food items by the use by date in the dry storage room. Food items were left open to air in 1 of 1 walk-in freezer and a food item was not discarded by the use by date in the reach in refrigerator. Immediate Jeopardy began on 04/16/24 when residents were served undercooked fried chicken for lunch. The immediate jeopardy was removed on 04/19/24 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of	F 812	1. Based on record review, observations, and staff, resident, Registered Dietitian, and Food Service Provider Representative interviews the facility failed to ensure that fried chicken was completely cooked before serving to residents on lunch trays. Resident #54, Resident #21, Resident #37, Resident #51, and Resident #45 were noted as having consumed the undercooked fried chicken. In addition, the facility failed to have food items labeled with a use by or expiration date and discard food items by the use by date in the dry storage room. Food items were left open to air in 1 of 1 walk-in freezer and a food item was not discarded by the use by date in the reach in refrigerator. On 4/16/2024 The Administrator and Director of Nursing (DON) assisted Certified Nursing Assistants in removal of delivered trays containing chicken and tray carts to prevent any further tray deliveries. The DON notified the Physician and Medical Director. The physician□s order was to monitor the residents and report any gastrointestinal complaints including	

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F 812	Continued From page 71 compliance at a lower scope and severity level of an "E" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. Example #2 is cited at a lower scope and severity of a D. The findings included: 1. An interview was conducted on 04/17/24 9:30 AM with Nursing Assistant (NA) #6 revealed she was present during lunchtime in the dining room yesterday (4/16/24) and had observed the undercooked chicken served to residents. She stated she was assisting Resident #54 and when she cut further into the resident's chicken towards the bone the chicken was pink, bloody, and appeared undercooked. When NA #6 looked at the plate further, she observed blood on the plate underneath the chicken. NA #6 stated she immediately picked up Resident #54's plate and took it into the kitchen and showed it to the Dietary Manager (DM) #1 and informed her the chicken was undercooked. NA #6 stated Dietary Manager #1 took Resident #54's plate with a look of shock on her face and stated the chicken was not cooked. NA #6 explained after that they were told by the Administrator and DM #1 to pull all the residents trays out of the dining room and off the halls and they would provide them with all new trays. She stated she observed other residents in the dining room had eaten some of the chicken on their plates prior to them pulling them and she just informed them that they would be bringing them a fresh tray shortly. On 04/16/24 at 12:15 PM an observation was	F 812	abdominal pain, nausea, vomiting or diarrhea. All unlabeled, open to air, and expired food items in dry storage and walk-in freezer were discarded. 2. On 4/16/24, The Administrator, DON, and regional nurse interviewed all residents to ensure no other residents consumed chicken. No further residents identified. The Administrator also completed an audit of all areas in the facility that contain food items for any unlabeled, open to air, or expired food items. Any items noted were discarded. 3. On 4/16/2024, The Regional Dietary Manager provided one on one re-education with the facility cook on proper use of recipe cards, food products, and appropriate food temperatures and process. All dietary staff were re-educated by Regional Dietary Manager/designee by 4/19/2024 with reference to facility policy on food safety requirements and preparation and storage guidelines, proper cooking temperatures and potential for food-borne illnesses and the importance of maintaining food temperature logs, labeling opened food items, keeping open food items covered, and discarding expired food items. All staff were educated by the Dietary Manager/Designee by 4/19/2024 with reference to facility policy on food safety requirements and potential for food borne illness related to consuming undercooked food as well as proper procedure to	

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F 812	Continued From page 72 conducted of the 200 halls during the lunch meal. Staff were observed passing trays to 4 residents. Staff were observed immediately removing two of the trays from (Resident #5 and Resident #6). The other two residents on the hall had received a mechanical soft diet with precooked chopped chicken and their meals were left in the rooms. The Administrator was observed pushing the meal cart back towards the kitchen. A continuous observation of the kitchen that included interviews occurred on 04/16/24 from 12:10 PM until 1:45 PM. The door to the kitchen was propped open by a meal cart with several other meal carts in the kitchen, all with resident trays. DM #1, Clinical Nutrition Manager, Dietary Aide (DA) #1 and Cook #1 were observed looking at a piece of fried chicken that had been cut in to and the meat was pink and red colored juices on the plate. DM #1 was asked what was going on and she replied they were having to pull all the fried chicken because it was undercooked and bloody. DM #1 explained the Administrator made the decision to remove all the fried chicken from the residents for safety reasons and a different meal had to be prepared. Dietary Aide (DA) #1 and DA #2 were removing trays from tray carts, and dumping the food into the trash can. Two other dietary aids were running all plates, silverware, plate warmers, lids, and trays through the dishwasher. Cook #1 was clearing all the food off the serving line and then began preparing new side items. It was confirmed by DM #1 that 5 of the 15 residents that had been served the undercook chicken had eaten part of the chicken provided to them. The fried chicken that was being discarded into the trash can included breasts, wings, thighs, and legs and some of the chicken pieces had been partially consumed and	F 812	immediately remove and report any identified undercooked food items to Dietary/Designee, labeling opened food items, keeping open food items covered, and discarding expired food items. All newly hired staff will be educated during the orientation process by Dietary Manager/Designee. 4. Dietary manager/designee will conduct direct observation audits 2x/week x12 weeks of food temperature checks to ensure appropriate temp. prior to plating for meal delivery, and all food storage areas will be audited for presence of unlabeled, open to air, or expired food items. Administrator will bring results of audits to monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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others had not been touched. During the continuous observation pieces of the fried chicken that were sent back to the kitchen were cut into by Cook #1. The fried chicken was observed to be pink and undercooked in the middle and close to the bone and had red colored juices flowing from the chicken onto the meal plate. There was an observation of plates that had red colored juices on the plate that had seeped into the vegetables and sides on the plates on the counter tops in the kitchen. According to DM #1 all carts had been sent out and returned to the kitchen. Then Cook #1 removed an additional tray of fried chicken from the oven and temped chicken with a thermometer that was given to him by DM #2 and the temperature was 137 degrees Fahrenheit. This fried chicken was discarded. It was observed that the temperature on the oven was set at 170 degrees Fahrenheit. The Administrator was observed bringing fried chicken from a local fast-food restaurant and placing it on the kitchen counter. Dietary staff were then observed preparing new meal trays for residents that had their meal trays pulled.

Review of the food temperature sheet revealed a temperature of 168 degrees Fahrenheit was entered for the fried chicken on 4/16/24.

An interview on 04/16/24 at 2:40 PM with Cook #1 revealed this was only his second day working at the facility. Cook #1 stated that when he had questions about cooking fried chicken, that DM #2 showed him the recipe for fried chicken, and he followed the instructions. Cook #1 revealed that he had chicken breast, thighs, legs, and wings to prepare for the lunch meal. Cook #1 revealed that Dietary Manager #2 was working on

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the sides while he worked on preparing the chicken. Cook #1 reported that the chicken was cooked for 15 minutes in the frier, but then moved it to the oven because he felt the grease was old and dark and did not want the chicken to become too dark, so the chicken was placed in the oven to finish cooking. Cook #1 also reported he did not have a 2-inch pan, so he had to put all the chicken in a 4-inch pan instead, so the chicken pieces were piled on top of each other. He explained using a 2-inch pan would have allowed the chicken to be spread out and not sitting on top of each other so it would have cooked better in the oven. Cook #1 stated he believed since the chicken was piled on top of each other was why the top layer of chicken pieces were cooked but the chicken in the middle and lower layers was not cooked. He reported that the first time he pulled the chicken out of the oven it was not done, and he asked DA #1 who told him the chicken was not done after she cut into it and told him to put it back into the oven. Cook #1 indicated he failed to take the temperature of the chicken the second time it was taken out of the oven and reported he knew better and should have checked the temperature of the fried chicken pieces before sending food out. Cook #1 also stated he knew better than to leave the oven at 170 degrees Fahrenheit knowing that would not cook the chicken, but only keep it warm. The food temperature sheet was reviewed during the interview and Cook #1 confirmed there was an entry for the fried chicken on 4/16/24 of 168 degrees Fahrenheit but Cook #1 stated he did not write that temperature down.

An interview on 04/16/24 at 02:05 PM with DM #1 revealed the menu being served that day for lunch included fried chicken. The Dietary

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Manager explained the chicken had been thawed the prior evening, marinated and was dredged in flour and fried that morning prior to being served. When asked to clarify the type of chicken that had been prepared and served, she stated it was frozen, raw chicken that had been thawed. DM #1 also stated that this was a common recipe she had seen used at several of the facilities she had worked at prior. DM #1 indicated DA#1 reported to her the fried chicken was returned to the oven because it was not fully cooked the first time it was removed from the oven. DM #1 stated that a temperature of 168 had been documented on the food temperature sheet for the fried chicken but she did not know who had written that temperature down and Cook #1 denied writing it down. DM #1 revealed that Cook #1 stated he did not check the temperature of the fried chicken the second time the chicken was removed from the oven. DM #1 indicated Cook #1 was responsible for checking the temperature of the food before it was served to the residents on 4/16/24. Dietary Manager #1 reported she became aware of the fried chicken not being fully cooked when NA #6 came to the kitchen door and told them a resident had raw chicken. DM #1 then notified the Administrator of the issue with the fried chicken not being fulling cooked. DM #1 further stated that she was going to adjust dinner time since lunch was not served until 1:30 PM. DM #1 also stated that all new sides were prepared, and the Registered Dietician had approved all changes to the menu. She indicated she had only been working at the facility for a month and was always short-staffed. Dietary Manager #1 stated she thought Dietary Manager #2, who was from another facility, and Cook #1 were working together.

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An interview was conducted with DM #2 on 04/16/2024 at 3:00 PM. DM #2 stated she was from another facility and had been called in to help due to the facility not having enough kitchen staff. DM #2 stated she was asked to come and support DM #1 since she was new and was short staffed. DM#2 revealed that Cook #1 asked her about the chicken and DM #2 reported getting him the recipe for cooking fried chicken and told him to follow the recipe. DM #2 stated she was not with Cook #1 when he checked the temperature of the fried chicken, and she was not aware that the first time it was taken out of the oven it was not cooked all the way. DM #2 further added that if she had known the chicken was not cooked thoroughly, she would have provided Cook #1 with more assistance. DM #2 also revealed she was helping the best she could, but she felt like the kitchen was in chaos when she arrived at the facility, and she felt bad for the new employee (Cook #1). DM #2 also stated that when she started looking into the chicken situation, she noted that Cook #1 had turned the temperature on the oven to 170 degrees, so it was too low to cook the chicken.

A review of the recipe for fried chicken provided by Dietary Manager #2 revealed:
1. Wash and drain the raw chicken, and season with salt and pepper.
2. Combine eggs and milk in large mixing bowl and dip chicken in milk mixture.
3. Season flour with salt and paprika, and dredge chicken in season flour.
4. Melt shortening in a large skillet or pan and place chicken in hot grease and cook until golden brown on both sides and the internal temperature is reached. Hazard Analysis and Critical Control Point (HACCP). Cook to an internal temperature

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of 165 degrees Fahrenheit. And HACCP: hold food at 135 degrees Fahrenheit.

Interview on 04/16/24 at 3:15 PM with Cook #2 revealed she usually cooked for the facility, but they were short of staff today, so she was not cooking but working as a dietary aide on the serving line. Cook #2 stated since she was not cooking, she had not been responsible for temping the food and had not temped any of the food that was prepared. She further stated when Cook #1 had removed the chicken from the fryer after 15 minutes he asked her to check the chicken to see if it was done. Cook #2 said she cut into the chicken and told Cook #1 that it was not done so he had put the chicken into the oven to finish cooking. She indicated when the trays started coming back into the kitchen due to the undercooked chicken, she and the other dietary aide began tearing everything down, discarding all the food items and washing and sanitizing everything that had encountered the undercooked chicken.

An interview on 04/16/24 at 02:00 PM with DA #1 revealed she was not involved with the cooking process on 04/16/24 and Cook #1 was responsible for checking and writing down temperatures for the fried chicken. DA #1 further stated she had not temped any of the food during the meal preparation and she was not sure who had checked the temperature of the fried chicken prior to it being served to the residents. DA #1 recalled she did not know there was a problem with the fried chicken being undercooked until trays started being returned to the kitchen. She indicated once the issue was identified she began cleaning and washing all the service items that had been returned so they could prepare new

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trays for the residents.

An interview conducted with Resident #5 and Resident #6 on 04/16/24 at 12:20 PM revealed they had been told the chicken they received that day was undercooked. The interview revealed neither of the residents had time to remove the lid of the plate before staff came and removed the tray from the room.

An interview was conducted on 04/16/24 4:20 PM with Resident #54. Her most recent Minimum Data Set Assessment noted she had intact cognition. She stated she had been eating lunch around noon in the dining room and was served a fried chicken thigh on her plate. She revealed she had begun eating her chicken and the closer she got to the bone of the chicken she noticed the chicken appeared pink and bloody and there was blood on her plate underneath the chicken. Resident #54 stated NA #6 who was also in the dining room saw her chicken and the blood on her plate and immediately removed the plate from her and took the plate into the kitchen and informed her they would bring her a new tray shortly.

An interview was conducted with Resident #21 on 04/16/24 at 04:23 PM. His most recent Minimum Data Set Assessment (MDS) noted he had intact cognition. Resident #21 revealed he had eaten the top half of the fried chicken provided to him in his room on 04/16/24 at lunch time and staff returned to the room and removed the rest of his chicken telling him there was a problem, and he would get a different tray shortly. Resident #21 stated he was upset because the first half of the fried chicken he had eaten tasted good, and their chicken is usually not good at all.

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An interview was conducted with Resident #37 on 04/16/24 at 04:41 PM. Her most recent MDS noted she had intact cognition. Resident #37 revealed on 4/16/24 she was eating lunch in the dining room and had been served a fried chicken thigh and she first noticed the skin on the chicken was very brown and dark. The resident peeled the chicken skin back and took a few bites of the chicken and realized that it did not taste right. The chicken was chewy and appeared pink like it wasn't fully cooked. Resident #37 stated she stopped eating the chicken and NA #6 removed her tray and informed her they would bring her a fresh tray.

An interview was conducted with Resident # 51 on 04/16/24 at 04:45 PM. His most recent MDS noted he had intact cognition. Resident #51 revealed he had been served two fried chicken thighs for the lunch meal (4/16/24). He stated he ate the first thigh which did not appear to be pink on the inside however the texture tasted, "off". The interview revealed when he took a bite of the second chicken thigh it was red and bloody on the inside, which dripped onto his plate. He stated staff removed the plate and eventually he was provided with a new meal tray.

An interview was conducted with Resident #45 on 04/16/24 at 03:37 PM. Her most recent MDS noted she had moderately impaired cognition. Resident #45 revealed on 04/16/24 she was eating in the dining room for lunch and was served fried chicken. She stated she had been served a leg piece but reported "it was not good" so after the first bite she did not eat the chicken anymore. Resident #45 reported that NA# 6 came and removed her tray with everyone else's

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and eventually brought her a new lunch tray.

Interview on 04/16/24 at 3:45 PM with the Assistant Director of Nursing revealed she had been instructed to contact the Medical Director regarding the five residents who had been served the undercooked chicken.

An interview on 04/16/24 at 03:20 PM with the Clinical Nutrition Manager for the food service provider revealed Dietary Manager #2 stated that staff in the dining room were the ones who discovered the undercooked fried chicken and let the kitchen know there was a problem with the chicken. The interview further revealed there were plenty of pans in the kitchen, so she had no idea why Cook #1 said there were not enough pans to spread the chicken out instead of piling it on top of each other. Dietary Manager #2 further stated that Cook #1 should have checked the temperature of the chicken right before the serving line was started and if the chicken was not done it should have been cooked longer even if lunch had to be a little late.

An interview on 04/16/24 at 03:45 PM with the Registered Dietician (RD) revealed NA #6 showed her the undercooked fried chicken that day. The RD reported that she observed the piece of fried chicken that NA #6 identified as undercooked and reported she did see the red liquid on the plate. The RD stated the fried chicken was slightly bloody and it was immediately pulled from the dining room. The RD further stated all trays had been delivered to the halls, but not all had been delivered to residents when the issue with the undercooked fried chicken was identified. Then the Administrator instructed staff to pull all trays back to the kitchen.

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The RD indicated DM #1 had informed her that 5 residents had consumed the undercooked fried chicken. The RD denied being present during the preparation of the fried chicken and did not observe Cook #1 while he prepared or cooked the chicken. The RD was asked twice if the kitchen used raw chicken for its fried chicken recipe and she stated yes, both times. The RD further stated all her kitchens used raw chicken for their fried chicken recipe.

Review of nursing note written by Assistant Director of Nursing (ADON) on 4/16/24 at 12:15 PM revealed Resident #54 notified of undercooked chicken. Removed tray, replaced with another meal, notified provider and power of attorney (POA/ sister). Resident education done and if experience abdominal pain, nausea/ vomiting, chills, lightheadedness, diarrhea, gas, weakness, headaches, or anything abnormal to notify staff/nurse. Resident #54 indicated understanding by nodding her head up and down. Denies any symptoms at present. No orders received by provider. (This same nursing note was placed in Resident #21, #23, and #51 electronic chart).

An interview and review of a purchase order was completed on 04/18/24 at 10:58 AM with the Regional Director of Operations (RDO) for Dietary with the food service provider. The RDO stated the facility had previously used raw bone-in chicken but had just recently switched to using the frozen precooked breaded chicken and there was no way that the fried chicken on 4/16/24 could have been undercooked. She supplied a purchase order with a delivery date of 04/14/24 for precooked breaded chicken. The RDO stated that the fried chicken could not be undercooked

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because it was a precooked product. She reported they had just switched from frozen raw chicken to precooked frozen chicken. The RDO also stated she felt the dietary staff were confused about what they were cooking and that it was precooked chicken. When the RDO was asked about the recipe instructions for fried chicken using raw chicken, she stated she did not know why the recipe was written the way it was since they no longer ordered raw chicken, so they needed to update the recipe. The RDO stated the Cook #1, Dietary Manager #1, and Dietary Manager #2 had since calmed down and she reported that their stories had changed and Cook #1 had checked the temperature of the fried chicken the second time it was pulled from the oven and the temperature was 168 degree Fahrenheit. The RDO was asked why the Registered Dietician would have confirmed the recipe was prepared using raw chicken and by the fried chicken recipe on 4/16/24. The RDO stated they just switched to pre-cooked chicken and was not sure if there was still raw chicken in kitchen freezer, or maybe the supplier had sent the wrong product. The RDO stated she was not present in the facility on 4/16/24 and wished someone had taken a picture of the undercooked fried chicken and was unable to produce the packaging the chicken had come from.

An interview on 04/18/24 at 02:38 PM with the Administrator revealed food being served to the residents should have temperature checks and be in expected ranges before it is served to the residents. The Administrator stated that DM #1 reported the undercooked fried chicken to her immediately after DM #1 became aware (on 4/16/24) and she went to the kitchen to see the undercooked chicken. The interview revealed

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after the Administrator observed the fried chicken, the decision was made to remove and discard all the fried chicken. The Administrator reported she was happy about how all the staff handled the situation once the issue was identified. The Administrator stated that education had been started for all dietary employees concerning correct food temperatures.

A conference call on 04/18/24 at 4:10 PM with the survey team, Administrator, Clinical Educator, Director of Clinical Asset Management for the food service provider, Clinical Nutrition Manager for the food service provider, Vice President of Operations for the food service provider, Vice President of Operations for the facility, owner and Chief Executive Officer of facility, revealed the facility and the food service providers maintained the fried chicken on 4/16/24 could not have been undercooked because the product was in fact frozen precooked chicken that was prepared and served to the residents. The Director of Clinical Asset Management stated there was no raw chicken in the kitchen, only precooked chicken as indicated by the purchase order she had provided to the survey team. She also stated she had interviewed the 4 residents that were identified as having received undercooked fried chicken and they had denied being served undercooked chicken. The Vice President of Operations for the food service provider indicated Cook #1 had embellished what he had told the survey team about how he had prepared and cooked the fried chicken. The Vice President of Operations also stated what NA #6 had cut into in the dining room was the blood line of the chicken close to the bone and said it was always dark reddish in color. The Vice President of Operations further indicated the cook time for raw chicken should

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have been 15 to 30 minutes in the fryer per the guidelines and then held in the warmer or oven at 140 degrees Fahrenheit until ready for service. During the conference call the Administrator stated she had not actually laid eyes on the fried chicken so she could not speak to what it looked like.

The Administrator was notified of immediate jeopardy on 04/16/2024 at 05:25 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

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

On 4/16/2024 at about 11:30 am, a facility Certified Nursing Assistant assigned to the dining room observed undercooked chicken served to two residents in dining room at the beginning of lunch service. The Certified Nursing Assistant immediately removed trays from affected residents to prevent consumption of the undercooked chicken and informed the Nurses assigned to those residents to ensure safety.

On 4/16/2024 The Vice President of Human Resources was in dining room during the incident and immediately notified Administrator and Director of Nursing of observed undercooked chicken being served in the dining room. The Administrator and Director of Nursing immediately notified dietary staff and went to halls in which trays were being served, where trays had been delivered to 1 out of 3 halls. Administrator and Director of Nursing assisted Certified Nursing Assistants in removal of delivered trays

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containing chicken and tray carts to prevent any further tray deliveries.

On 4/16/2024 The Director of Nursing and Administrator identified 15 residents were served and 5 consumed the undercooked chicken.

On 4/16/2024 The Director of Nursing notified the Physician and Medical Director. The physician's order was to monitor the residents and report any gastrointestinal complaints including abdominal pain, nausea, vomiting or diarrhea.

On 4/16/2024, The kitchen staff discarded the chicken dinners, including fried chicken, macaroni, cheese, and spinach. The trays were cleaned using sanitizer and high temperature. An alternative meal was prepared and served to residents in accordance with the facilities' food preparation policy. The facility management bought chicken from a local fast-food restaurant and new side items were prepared in the kitchen.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 4/16/2024 the Administrator notified Regional Dietary Manager of the situation and she informed administrator she was in route to the building. Dietary Manager re-educated immediately by Regional Dietary Manager on safe food handling, potential food borne illnesses and proper cooking temperatures on 4/16/2024.

On 4/16/2024, The facility cook informed the Administrator and Regional Dietary Manager that temperature of 168 degrees Fahrenheit was

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obtained from top layer of prepared chicken prior to serving lunch service. The temperature log was also reviewed by the Administrator and confirmed the documented chicken temperature of 168 degrees Fahrenheit.

On 4/17/2024, all dietary staff were re-educated verbally by Regional Dietary Manager with reference to facility policy on food safety requirements and preparation guidelines. This included proper cooking temperatures and potential for food-borne illnesses and emphasized the importance of maintaining food temperature logs.

The Dietary Manager/designee will educate any dietary staff not educated on 4/17/2024 before their next scheduled shift. All newly hired dietary staff will be verbally educated upon hire by the Dietary Manager/Designee on food safety requirements and preparation guidelines, to include proper cooking temperatures and potential food borne illnesses. Employees must verbalize understanding and have required competencies including accurate thermometer readings.

On 4/17/2024, all staff including newly hired staff will be verbally educated by the Dietary Manager or Designee with reference to facility policy on food safety requirements and potential for food borne illness related to consuming undercooked chicken as well as proper procedure to immediately remove and report any identified undercooked food items to Dietary/Administrator/Director of Nursing/Designee. Any staff member who did not work on 4/17/2017 will receive the education from the Dietary Manager prior to the start of their next

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shift. Administrator/Vice President of Dietary Operations /Designee will monitor for 100% completion.

On 4/17/2024 the Vice President of Dietary Operations instructed dietary staff that a temperature check must be performed for at least 3 pieces of chicken per layer, followed by verification of temperature before serving. Dietary staff were also educated by Dietary Manager using approved recipe cards and food products.

On 4/16/2024, The Regional Dietary Manager provided one on one re-education with the facility cook on proper use of recipe cards, food products, and appropriate food temperatures and process.

Alleged date of immediate jeopardy removal: 04/19/24.

The immediate jeopardy removal plan was validated on 4/23/24. Review of education sign-in sheets revealed all dietary and facility staff were educated on signs and symptoms of foodborne illnesses, identifying undercooked food, and what to do in the event of finding undercooked food. The kitchen staff were able to describe the process of checking food temperatures and having another kitchen staff member to verify the temperature, as well as testing multiple areas of the food for temperature. Observations of the kitchen on 4/23/24 revealed no concerns with food preparation, checking food temperatures before plating or tray line. An Ad Hoc QAPI was conducted on 4/17/24. During an interview the Administrator confirmed they are putting a hold on purchasing raw chicken for residents until they were certain the corrections were sustained. The

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immediate jeopardy removal date of 4/19/24 was validated.

2. a. A tour of the kitchen was conducted with the Dietary Manager (DM) #1 on 04/15/2024 at 11:20 AM. Observations in the dry storage room revealed a plastic bin on a shelf that contained 10 to 15 bags of instant chocolate pudding bags. A crumbly dry substance was observed on and under the bags and there was no use by or expiration date on the bags of pudding. DM #1 could not identify what the substance was, but stated she would get it cleaned up. DM #1 stated the expiration date for the instant chocolate pudding was on the box they came in but that the boxes had been thrown away. In addition, there was an open bag of dried pasta with a use by date of 03/29/24. Dietary Manager #1 took the bag of dried pasta and removed it from dry storage.

b. Observation of the walk-in freezer on 04/15/2023 at 11:35 AM revealed an open box of bacon on a shelf. The plastic bag surrounding the bacon in the box was not sealed shut and the bacon was left open to air inside of the box. DM #1 was observed closing up the bacon, so it was no longer exposed. In addition, there was a package of sliced American cheese open to air with individual slices observed in other boxes on the same shelf. There was no date on the box of bacon or the package of cheese to indicate when they were opened. DM #1 took the cheese and removed it.

c. Observation of the reach-in refrigerator on 04/14/2024 at 11:42 revealed an unlabeled container of dried shredded cheese which DM #1 identified as parmesan cheese. It was noted on

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F 812	Continued From page 89 the container that the use by date was 04/09/2024. The Dietary Manager #1removed the container from the refrigerator and threw it away. Interview with Dietary Manager #1 on 04/15/2024 at 11:50 AM revealed the cook for the day was responsible for checking dates before food was prepared. She also stated that all dietary employees were supposed to date all food items when they were opened and check products and to discard any expired food items. DM #1 stated was new to the position and is still trying to get things in order.	F 812		
F 867 SS=E	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 not limited to the facility assessment required at §483.70(e) and including how such information	F 867		5/8/24

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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 ensure that improvements are sustained.

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F 867	Continued From page 91 §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) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

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F 867	Continued From page 92 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 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 investigation survey that occurred on 12/16/21, the recertification and complaint investigation survey that occurred on 12/30/22 and the complaint investigation survey that occurred on 02/23/23. This failure was for one deficiency that was originally cited in the area of Free of Accidents Hazards/Supervision (F689). The recertification and complaint investigation survey that occurred on 12/16/21 and the recertification and complaint investigation survey that occurred on 12/30/22. This failure was for one deficiency that was originally cited in the area of Food Procurement, Store/Prepare/Serve Under Sanitary Conditions (F812) and this was subsequently recited on the current recertification and complaint investigation survey of 04/23/24. The repeat deficiencies during multiple surveys of record show a pattern of the facility's inability to sustain an effective QA program. The findings included:	F 867	Facility Administrator conducted a Quality Assurance and Improvement Committee meeting on 4/23/2024 to discuss the recitation of tag 880, 689 and 812. All residents residing at the facility have the potential to be affected. Facility Administrator and Regional Clinical Nurse Consultant re-educated the Interdisciplinary team and members of the Quality Assurance and Performance Improvement Committee on 4/23/24 regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure state and federal compliance in the facility. Any Interdisciplinary Team Member that has not received the Quality Assurance and Performance Improvement education on or after 4/23/24 will be unable to work until he/she has received the Quality Assurance and Performance Improvement education. All new Interdisciplinary Team Members newly hired will be educated on Quality	

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F 867	Continued From page 93 This tag is cross referred to: F689: Based on observations, record reviews, and staff interviews the facility failed to maintain an environment free of accident hazards for 1 of 5 residents (Resident #66) reviewed for supervision to prevent accidents. On 2/21/24, Resident #66 who was severely cognitively impaired with a history of wandering was observed by Nursing Assistant (NA) #6 attempting to cut her cast off her left arm using a "long ridged knife with handle." Resident #66 was unattended in the hallway outside of the maintenance room, the door was unlocked and partially open. NA #6 asked Resident #66 to hand her the "long ridged knife with handle" which she did with no issues, placed the knife back inside the maintenance room and shut the door without locking the door. The maintenance room was observed on 4/17/24 to be unlocked. This practice has a high likelihood that residents could access materials that could cause serious harm or injury. During the complaint investigation survey conducted 02/23/23, the facility failed to ensure the securement of the resident and her chair was according to the manufacturer's recommendations to provide a safe van transport for a resident reviewed for accidents/hazards. During the recertification and complaint investigation survey conducted 12/30/22, the facility failed to provide care in a safe manner for residents and the facility failed to investigate the injury and complete a root cause analysis and as a result no plan was in place to prevent further injury to resident. In addition, the facility failed to complete accurate smoking assessments to provide a safe smoking environment for residents	F 867	Assurance and Performance Improvement on date of hire by Assistant Director of Nursing (ADON)/designee. The Interdisciplinary Team, including the facility Medical Director, will meet monthly to conduct the facility□s Quality Assurance and Performance Improvement meeting. Special attention will be given to assessing the effectiveness of the monitoring of repeat deficiency 689, 812 and 880 as well as the prevention of any new repeat deficiencies. Should any interdisciplinary team member find that the facility may need an Impromptu Quality Assurance and Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members for a revision to a present action plan or for a need for new action plan in order to maintain compliance in the facility. Quality Assurance monitoring will take place at each QAPI meeting monthly and any impromptu meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and performance Improvement committee. F812, F880 and F689 will be reviewed by the QAPI committee for 6 months.	

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reviewed for smoking.

During the recertification and complaint investigation survey conducted 02/23/21, the facility failed to secure bleach used by a resident for personal for a resident reviewed for accidents/hazards.

F812: Based on record review, observations, and staff, resident, Registered Dietitian, and Food Service Provider Representative interviews the facility failed to ensure that fried chicken was completely cooked before serving to residents on lunch trays. Undercooked fried chicken was served to 15 of 69 residents and 5 of 15 residents consumed the undercooked fried chicken. Resident #54, Resident #21, Resident #37, Resident #51, and Resident #45 were noted as having consumed the undercooked fried chicken. This unsafe food handling practice had a high likelihood for food borne illness for residents. In addition, the facility failed to have food items labeled with a use by or expiration date and discard food items by the use by date in the dry storage room. Food items were left open to air in 1 of 1 walk-in freezer and a food item was not discarded by the use by date in the reach in refrigerator.

During the recertification and complaint investigation survey conducted 12/30/22, the facility failed to label, date, and seal open food items for use in the walk-in refrigerator and reach in cooler. This practice had the potential to affect the food served to residents.

During the recertification and complaint investigation survey conducted 12/16/21, the

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F 867	Continued From page 95 facility failed to label and date opened food items, failed to store food in closed containers, failed to remove dented cans, failed to keep floor in dry storage free of debris in the dry storage room reviewed for food storage. An interview on 04/18/24 at 5:10 PM with the Administrator revealed their Quality Assurance and Process Improvement (QAPI) meetings were held monthly every 3rd Tuesday. She stated the department heads, Medical Director, pharmacist, and registered dietician attend the meetings. The Administrator further stated they had Process Improvement Plans in place for their renovations and physical plant operations and had completed plans for water temperatures and tracheostomy care. She indicated she felt like the repeat deficiencies were related to turnover in department heads and turnover of staff and because there were not systems in place for staff or accountability of staff and she was trying to get those things in place.	F 867		
F 880 SS=J	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:	F 880		5/24/24

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F 880	Continued From page 96 §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 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.	F 880		

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F 880	Continued From page 97 §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, picture, manufacturer's instructions, resident, family member #5, staff, consultant pharmacist, and Medical Director interviews the facility failed to ensure that single resident insulin pens were not shared between residents. On 07/10/23 Nurse #10 administered insulin to Resident #171 using Resident #172's insulin pen. Insulin pens are designed to be used multiple times by a single resident only and must never be shared. Regurgitation (emission) of blood into the insulin cartridge after injection will create a risk of bloodborne pathogen transmission if the pen is used for more than one resident, even when the needle is changed. This has the high likelihood to spread bloodborne pathogens such as human immunodeficiency virus (HIV), Hepatitis B and Hepatitis C. This affected 1 of 3 residents reviewed for infection control. The facility also failed to initiate Enhanced Barrier Precautions (EBP) for residents with medical devices and non-chronic wounds such as indwelling catheters and tracheostomies for 4 of 4 residents reviewed with medical devices and wounds (Resident #1, Resident #19, Resident #26, and Resident #57).	F 880	1.The facility failed to ensure that a single resident insulin pen was used for one resident (Resident #171). On 7/10/23 Nurse #10 used Resident #172's insulin pen to give short acting insulin to Resident #171. The Director of Nursing notified the Medical Director and the Physician on 7/11/2023. There were no new orders. The Insulin pen for Resident #172 was discarded, and new ones were ordered on 7/11/2023. Resident #172 did not receive insulin from the reused insulin pen. The facility also failed to initiate Enhanced Barrier Precautions (EBP) for residents with medical devices and non-chronic wounds such as indwelling catheters and tracheostomies for 4 of 4 residents reviewed with medical devices and wounds (Resident #1, Resident #19, Resident#26, and Resident #57). The facility further failed to change gloves during incontinent care and before touching the resident's environment (Resident #35).	

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F 880	Continued From page 98 The facility further failed to change gloves during incontinent care and before touching the resident's environment (Resident #35). Immediate Jeopardy began on 07/10/23 when Nurse #10 administered insulin to Resident #171 using a pen that belonged to Resident #172. Immediate jeopardy was removed on 04/19/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal The facility will remain out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring system are in place. Example #2 and #3 are being cited at a lower scope and severity of an E. The findings included: 1. Review of an article published on the National Library of Medicine website January 2008 read in part, the most common method of open loop insulin delivery is the subcutaneous insulin injection. In addition to the basal requirements the patient will inject insulin into subcutaneous tissue prior to meals. To provide rapid insulin during this situation a fast-acting insulin such as insulin aspart or insulin lispro is used. Review of a facility policy dated 11/01/20 read in part, Insulin Pen: insulin pens contain multiple doses of insulin but are used for single residents only. Review of manufacturer's instructions for Lispro insulin revised in July 2023 read in part, do not share your insulin Lispro (insulin in a pen form	F 880	2. The Director of Nursing reviewed residents who receive insulin via pen in July 2023. The Director of Nursing (DON) conducted an audit of all residents currently prescribed insulin to determine that all residents who receive insulin had a pen specific to the prescribed medication and dosage. On July 12, all Residents who receive insulin via pen, received a new pen, labeled with their name, drug and dosage. On 4/19/24 the DON notified the Health Department and was given recommendations to notify all residents who receive insulin of a potential exposure and offer testing for communicable diseases. Recommendations were completed by DON. By 5/23/24 DON/Designee reviewed and implemented Enhanced Barrier Precautions (EBP) on all required residents per facility policy including wounds (Resident #1, Resident #19, Resident#26, and Resident #57). Certified Nursing Assistant #5 was re-educated by 4/18/24 by DON on proper hand washing per facility handwashing and incontinent care policies. 3. On July 11, 2023, the Director of Nursing and Assistant Director of Nursing completed education for all nursing staff, including LPNs, RNs, and Medication Aides. The lesson plan covered the following topics: Insulin pens are Resident specific, nurses may not exchange insulin pens for use with that of a different resident, if a resident does not have the required pen notify the supervisor, physician and pharmacy and medical	

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F 880	Continued From page 99 that has a reservoir that holds the insulin and a rubber end that is punctured when the small needle is applied to administer the insulin) pen with other people even if the needle has been changed. You may give other people a serious infection or get a serious infection from them. Resident #171 was admitted to the facility on 04/22/23 and was discharged on 09/06/23. Resident #171's diagnoses included diabetes mellitus. Resident #171 resided on the 200 hall at the time of the incident. Review of a physician's order dated 06/24/23 read, Admelog (Lispro insulin fast acting) for blood sugar 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units give subcutaneously three times a day for diabetes at 8:00 AM, 12:00 PM, and 4:00 PM. An admission Minimum Data Set (MDS) dated 06/30/23 indicated Resident #171 was cognitively intact. Review of the Medication Administration Record (MAR) dated July 2023 revealed that on 07/10/23 Nurse #10 administered Admelog insulin at 8:00 AM, 12:00 PM, and 4:00 PM. Review of a progress note for Resident #171 written by Nurse #11 dated 07/11/23 at 11:13 AM read; new insulin Lispro opened from e-kit. Reordered insulin Lispro from pharmacy. Will update as needed. Resident #171 was interviewed via phone on 04/15/24 at 4:31 PM. She stated that she resided at the facility for a few months. Resident #171 stated that on 07/10/23 at 6:06 PM (time on her cell phone) Nurse #10 came into her room to give	F 880	director. By 5/23/24 education and competencies were completed with all nursing staff on facility policies regarding handwashing and incontinent care by Regional Nurse Educator/designee. By 5/23/24 education was completed with all nursing and therapy staff on facility policy for EBP by DON/designee. All new hires, including agency staff will be educated during the orientation process by DON/Designee. 4. The Director of Nursing (DON)/designee will audit 2x/week for 12 weeks to ensure residents who receive insulin have individual pens as well as random staff observations for handwashing and EBP compliance. Results of observations will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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her an insulin shot. Resident #171 could not recall what her blood sugar was but stated that after Nurse #10 had checked her sugar, she required several units of insulin. She stated Nurse #10 had laid the cap to the insulin pen that she used to administer her insulin on her bedside table and after she had given the insulin shot to Resident #171, she (Resident #171) noted that the label that was on the insulin pen cap had Resident #172's name on it. Resident #171 stated she asked Nurse #10 about it, and she stated that it was left at the facility by another resident and was ok to use. Resident #10 stated that she reported the incident to Nurse #11 the next morning on 07/11/23 and to family member #5. She added she had no ill effects from receiving Resident #172's insulin

A cell phone picture provided by Resident #171 on 04/15/24 revealed an insulin pen with the red connector to the lower insulin reservoir noted with a label that contained Resident #172's name, room number, type of insulin, prescription number and fill date on the pens cap. The type of insulin was Lispro insulin (fast acting insulin).

Observations made on 04/17/24 at 2:38 PM of the medication carts revealed Lispro insulin pens for other residents that all contained the label and instructions on the cap of the pen. Each pen had a red connector that was attached to the pen reservoir and when removed the pen cap did not contain the red connector.

Family member #5 was interviewed via phone on 04/16/24 at 5:03 PM. The family member stated that Resident #171 had called her and told her a nurse had used another resident's insulin pen to administer insulin to her (Resident #171) and had

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sent her a picture of the "insulin pen." The family member stated she reported the issue to the Director of Nursing (DON) in July 2023 after the incident occurred but had not heard anything back from her. The DON told the family member she "would address it."

Resident #172 was admitted to the facility on 05/28/23 and was discharged on 08/09/23. Resident #172's diagnoses included diabetes mellitus. Resident #172 resided on the 300 hall at the time of the incident.

A physician's order dated 05/29/23 read, Lispro insulin for blood sugars 200-250=2 units, 251-300=4 units, 301-350=6 units, and 351-400= units subcutaneously before meals.

Nurse #10 was interviewed via phone on 04/16/24 at 5:10 PM. Nurse #10 confirmed she no longer worked at the facility. She stated when she did work at the facility, via an agency, she was a hall nurse and administered medications including insulin. Nurse #10 stated "I have seen them share insulin pens there (at facility), but I have not done it because it messes up when they can get a refill." Nurse #10 stated "she had never had to do that in this building" referring to sharing insulin pens. Nurse #10 recalled Resident #171 but stated she did not recall giving her insulin from another resident's insulin pen. She added that the facility had "availability issues with medications because the staff were not reordering them like they should."

Nurse #11 was interviewed via phone on 04/17/24 at 11:59 AM. Nurse #11 confirmed she no longer worked at the facility. Nurse #11 recalled that on

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07/11/23 Resident #171 had reported to her that "the cap from the insulin pen that was used the previous night was left at bedside and it was not her insulin." Nurse #11 stated she reported the issue to the DON. After she reported the incident to the DON, she was asked by the DON to educate all the nursing staff about insulin pens and how to use them, how to reorder them, and how to store them. Nurse #11 stated that was the only incident she heard about of staff sharing insulin pens and she was aware that you were not supposed to share insulin pens.

The Consultant Pharmacist was interviewed on 04/16/24 at 3:09 PM. The Pharmacist stated staff should not be sharing insulin pens, they are designed to be used multiple times by one resident only. She explained that when insulin pens first came out, they marketed the insulin pens as they could be used on multiple residents as long as you changed the needle between residents but then they discovered that those residents who shared insulin pens had Hepatitis C and the guidance was changed that you could not share the pens even if you changed the needle.

The DON was interviewed on 04/16/24 at 3:59 PM and again on 04/18/24 at 2:45 PM. The DON stated it was reported to her that there was an insulin pen cap found in Resident #171's room that did not belong to her. She stated she interviewed Resident #171 on 07/11/23, and she stated that the cap to the insulin pen that was used on her last evening had another resident's name on it. She also interviewed Nurse #10 who was certain that she had not shared the insulin pen. However, the DON stated on 07/11/23 she went through and made sure that

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each resident who was prescribed insulin had a supply of their prescribed insulin either on the medication cart or in the refrigerator. During the initial audit of the insulin, they discovered that some residents did not have a supply of insulin but Resident #171 was not one of those residents. The DON stated that she was instructed by the Administrator to replace everyone's insulin pen despite the high cost and all nursing staff were educated on the usage of insulin pens, how to reorder them and how to store them. The DON again stated she could not confirm that the insulin was given from another resident's pen, but they decided to put together a plan to correct any issue that they had. The DON was asked to run a report from July 2023 to October 2023 of residents that had diagnoses of bloodborne disease, and she stated she unable to do so.

The Administrator was interviewed on 04/18/24 at 11:54 AM, she stated she was aware of the insulin pen issue. From what she understood, it was "just a cap that was discovered" but she asked the DON to cover all the bases, and everyone got new insulin pens from the pharmacy. The Administrator stated she did not want any of her staff to share insulin pens as it is never appropriate to share the pens. She stated that the MD had stated to her that the insulin pens were a closed system as long as the needle was removed, and a new one put on.

The Medical Director (MD) was interviewed via phone on 04/17/24 at 4:20 PM. The MD stated that Lispro insulin and Admelog insulin were very similar and were in the same category of insulin and that there was no adverse effects from giving one or the other. The MD stated, "it is not ideal to

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share insulin pens, but it can be done in certain circumstances because they are changing the needles, but it is better if you don't share them." The MD stated he had never heard of anyone at the facility sharing insulin pens and he only been the MD since October of 2023.

The Administrator was notified of Immediate Jeopardy on 04/18/24 at 11:09 AM.

The facility provided the following credible allegation of immediate jeopardy removal:

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

The facility failed to ensure that a single resident insulin pen was used for one resident (Resident #171). On 7/10/23 Nurse #10 used Resident #172's insulin pen to give short acting insulin to Resident #171
Nurse #10 is no longer employed at the facility.

The Director of Nursing notified the Medical Director and the Physician on 7/11/2023. There were no new orders. The Director of Nursing initiated an investigation and collected statements.

On 7/11/2023 the Director of Nursing notified the pharmacy of Resident #172's insulin pen used for Resident #171. The Director of Nursing ordered new insulin pens for all residents with a physician order for insulin.
The Insulin pen for Resident #172 was discarded, and new ones were ordered on 7/11/2023.
Resident #172 did not receive insulin from the reused insulin pen. Resident #172 was

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discharged 8/09/23 and no longer resides in the facility.

Resident #171 notified the facility of deficient practice on July 11,2023. On 7/11/2023, new insulin pens were reordered, and the previously used pens were discarded. The Resident was assessed by the physician on 7/28/2023 with no new orders. The Resident was discharged from the facility on 9/6/2023.

The Director of Nursing reviewed residents who receive insulin via pen in July 2023. The Director of Nursing conducted an audit of all residents currently prescribed insulin to determine that all residents who receive insulin had a pen specific to the prescribed medication and dosage. On July 12 2023 All Residents who receive insulin via pen, received a new pen, labeled with their name, drug and dosage.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On July 12,2023 Nurse #10 who was employed through agency contract was terminated.

On July 11, 2023, the Director of Nursing and Assistant Director of Nursing conducted an in person verbal in-service for 100% of nursing staff, including LPNs, RNs, and Medication Aides. The lesson plan covered the following topics:

-Insulin pens are Resident specific.
-Nurses may not exchange insulin pens for use with that of a different resident.
-If a resident does not have the required pen

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notify the supervisor, physician and pharmacy and medical director.

On July 11, 2023 all staff who received the in-service verbalized understanding.

The infection control policy was reviewed by the Director of Nursing and the Regional Nurse Consultant on July 11, 2023, to ensure it includes bloodborne pathogens and the use of insulin pens. No revisions were necessary.

On 7/11/2023, the Director of Nursing notified the Assistant Director of Nursing (who is responsible for staff education) to provide education on the policy prior to the start date for all new nursing hires (LPN, RN, Medication Aids).

On 4/17/24 the Director of Nursing notified the Health Department that on 7/11/2023 it was reported by Resident #171 that Nurse #10 administered insulin using a pen belonging to Resident #172
Immediate jeopardy removal date is 4/19/24

A validation of immediate jeopardy removal was conducted on 04/23/24. Interviews with nursing staff revealed they were aware to never share insulin pens, how to reorder them, how to store them, and how to utilize the backup medication system if a resident was out of their prescribed insulin. A medication pass was completed that included insulin administration with no issues noted and a medication error rate of 0%. The initial audit of all residents' insulin was reviewed as was the order form and confirmation from the pharmacy indicating that they had received the order for insulin pens for the residents that were in the building. Education sign in sheets were

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reviewed with no concerns noted. The DON verbally confirmed that the education was included in the new hire orientation program and that she had contact the health department to notify them of the reported incident. Attempts to notify the local health department of the incident were made on 04/17/24 and 04/18/24. The facility's removal date of 04/19/24 was validated.
2. Review of the facility's policy and procedure last updated and implemented on 04/01/24, entitled "Enhanced Barrier Precautions" read in part:
under "Policy:" "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms." Under "Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities." Under "Policy Explanation and Compliance Guidelines:
2. Initiation of Enhanced Barrier Precautions (EBP):
a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with a multi-drug-resistant organism (MDRO) that is not currently targeted by the Centers for Disease Control and Prevent (CDC).
b. An order for enhanced barrier precautions will be obtained for residents with any of the following:
i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers) and/or indwelling

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F 880	Continued From page 108 medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. ii. Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply. 4. High contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing" a. Observation on 04/15/24 at 11:15 AM of Resident #57 revealed she had a gastrostomy tube for which she was receiving bolus feedings and she had a tracheostomy tube. There was no personal protective equipment (PPE) available outside her door. b. Observation on 04/15/24 at 12:07 PM of Resident #1 revealed she had an indwelling urinary catheter and an unstageable wound to her right hip area. There was no personal protective equipment (PPE) available outside her door. c. Observation on 04/15/24 at 12:30 PM of Resident #26 revealed he had an indwelling urinary catheter. There was no personal protective equipment (PPE) available outside his door.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 109	F 880		

d. Observation on 04/15/24 at 2:36 PM of Resident #19 revealed he had a stage III pressure ulcer on his left buttock. There was no personal protective equipment (PPE) available outside his door.

e. Observation on 04/16/24 at 4:00 PM of Resident #20 revealed she had chest catheter access for dialysis with a dressing on the catheter site. There was no personal protective equipment (PPE) available outside her door.

Interview on 04/18/24 at 2:55 PM with the Director of Nursing (DON) who was also the Infection Preventionist (IP) revealed she was aware of the new guidelines for placing residents with wounds and internal medical devices such as urinary catheters, gastrostomy tubes and tracheostomy tubes on Enhanced Barrier Precautions (EBP) effective 04/01/24. She stated they had not yet educated their staff on the procedures and had placed an order for caddies but had not received them and she had not implemented the guidelines. The DON/IP stated she was aware that it was supposed to be implemented effective 04/01/24 but she had not implemented the new guidelines at the facility and admitted the staff were not aware they needed to be wearing PPE during high contact resident care for residents with wounds, urinary catheters, feeding tubes, tracheostomy tubes and central catheters. She further stated that she should have already implemented the procedure at the facility effective 04/01/24.

3. Review of the facility's policy and procedure implemented on 11/01/20, entitled "Hand Hygiene" read in part:

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F 880	Continued From page 110 under "Policy Explanation and Compliance Guidelines: 3. Alcohol-based hand rub is the preferred method for cleaning hands in most clinical situations. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves. Hand Hygiene Table - use either soap and water or alcohol-based hand rub (ABHR is preferred) After handling contaminated objects When, during resident care, moving from a contaminated body site to a clean body site After assistance with personal body functions (e.g., elimination, hair grooming, smoking) When in doubt." Observation on 04/15/24 at 11:27 AM revealed Nurse Aide (NA) #5 preparing to provide incontinence care to Resident #35. NA #5 donned her gloves and prepared wash cloths and wipes and proceeded to clean the resident on the front side from urine and then turned him on his right side and cleaned his back side and in between his buttocks from smears of stool. Once he was cleaned, with the same gloves on she placed a clean brief under the resident, opened his bedside drawer and removed a tube of barrier cream from the drawer, squirted it on her gloved hand and proceeded to rub the barrier cream on his buttocks. NA #5 then fastened his brief on the left side, turned him on his back and fastened the brief on the right side and adjusted his linens. NA #5 then doffed her gloves, sanitized her hands, and proceeded out of the room with a trash bag in her hand.	F 880		

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F 880	Continued From page 111 Telephone interview on 04/18/24 at 2:44 PM with NA #5 revealed she recalled caring for Resident #35 on 04/15/24. She stated she was nervous about being observed during resident care and forgot to doff her gloves after cleaning the resident and before applying barrier cream to his buttocks. She stated she knew the proper procedure for changing gloves when moving from a dirty to clean procedure but said she just forgot to do it because she was nervous about being watched. Interview on 04/18/24 at 2:58 PM with the Director of Nursing (DON) who was also the Infection Preventionist (IP) revealed NA #5 should have doffed her gloves after cleaning the resident, sanitized her hands and donned clean gloves prior to touching the resident's bedside table and applying barrier cream to his buttocks. She stated she would provide additional education to NA #5 regarding hand hygiene.	F 880		