STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING _____ B. WING _____	C 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-BLACK MOUNTAIN	62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 08/26/24 through 08/30/24. Additional information was obtained offsite for validation of the corrective action plan for F600 on 9/5/24. Therefore, the exit date was changed to 9/5/24. The facility was found in compliance with the requirement 483.73, Emergency Preparedness. Event ID# JJ7W11.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation were conducted from 08/26/24 through 08/30/24. Additional information was obtained offsite for validation of the corrective action plan for F600 on 9/5/24. Therefore, the exit date was changed to 9/5/24. Event ID# JJ7W11. The following intakes were investigated: NC00210090, NC00211397, NC 00213256, NC00218133, and NC00219320. 5 of the 5 complaint allegations did not result in a deficiency. Past noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity (G). Past noncompliance began on 11/18/23. The facility came back into compliance effective 11/30/23.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take	F 565		10/1/24

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

Electronically Signed | 09/19/2024

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F 565	Continued From page 1 reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated concerns and/or suggestions voiced by residents during Resident Council meetings for 6 of 7 months reviewed (August 2023, January 2024, March 2024, April 2024, May 2024, and	F 565	Element #1 The facility failed to resolve and communicate the facilities efforts to address repeated concerns and/or suggestions voiced by residents during Resident Council meetings. Items indicated as not having a follow up with	

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F 565	Continued From page 2 June 2024). Findings included: Review of the Resident Council Minutes for the period 08/17/23 through 08/15/24 revealed the following: a. A Resident Council Response Form attached to the 08/17/23 Resident Council meeting minutes noted residents voiced they did not have faith that anything they asked for would be done and no changes would be made. The resolution noted that the Administrator was working to reassure residents that they have been heard and explain that changes take time. The section at the bottom of the form indicating the date the resolution was reported back to the Resident Council and by whom was left blank. b. The Resident Council meeting minutes dated 01/11/24 noted a concern was voiced regarding the garbage truck driver and staff were driving too fast around the facility. The Resident Council Response Form attached to the 01/11/24 Resident Council meeting minutes noted a resolution that an inservice would be held with facility staff reminding them of the 10 MPH (miles per hour) speed limit around the facility and a call would be placed to the garbage company asking the truck driver to slow down to 10 MPH. The section at the bottom of the form indicating the date the resolution was reported back to the Resident Council and by whom was left blank. c. The Resident Council meeting minutes dated 02/29/24 noted no meeting was held due to the	F 565	residents, b) Garbage Truck driver driving too quickly in the facility parking lot, c) No meeting held due to Resident Council President was sick, e) Medications being delivered in a timely manner, g) Resident Council Minutes from prior meeting not read, h) When items reported back, not noting who reported back to the Resident Council. The Administrator and the Activity Director, or designee, will meet with Resident□s #10, #35, #36, #55, and #65 to provide response in writing to address prior outstanding concerns and answer any current questions regarding outstanding facility issues they feel have not been resolved by 09/30/2024. Element #2 All residents that attend Resident Council are at risk for this deficient practice. Any Resident Council meeting that is not held per the resident□s request, will be documented and rescheduled. This documentation will be signed-off on by the Resident Council President, or Vice President, in the President□s absence. All concerns identified during Resident Council Meetings will be documented via a Grievance Form and taken through the Grievance process. Any items for which there was not documentation of the follow-up or who provided the follow-up, will be discussed at the next Resident Council meeting, by 09/30/2024. Element #3 The Activity Director and Activity Assistants will be educated by the Administrator regarding the Resident	

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F 565	Continued From page 3 Resident Council President being sick. d. The Resident Council meeting minutes dated 03/21/24 revealed no indication that the minutes from the Resident Council meeting held on 01/11/24 were read, approved, revised and/or resolved. There was also no indication the facility's response to the concern regarding speeding that was voiced during the 01/11/24 meeting was communicated to the Resident Council under Old Business. Under New Business it was noted a nursing concern was voiced regarding medications not being delivered on time. The Resident Council Response Form attached to the 03/21/24 Resident Council meeting minutes noted a resolution that staff would be educated on the residents' requests of medication times. The section at the bottom of the form indicating the date the resolution was reported back to the Resident Council and by whom was left blank. e. The Resident Council meeting minutes dated 04/18/24 revealed no indication the facility's response to the concern regarding medications not being delivered on time that was voiced during the 01/11/24 meeting was communicated to the Resident Council. Further review revealed the section for Old Business was left blank. f. The Resident Council meeting minutes dated 05/16/24 noted concerns were voiced regarding speeding around the facility, medications not being administered on time, and the bird house in the courtyard needed to be stabilized. The Resident Council Response Form attached	F 565	Council Meeting policy and minutes by 09/30/2024. Element #4 The Resident Council President will be interviewed monthly x 6 months to ensure that the prior Resident Council Meeting minutes are reviewed at each Resident Council Meeting and that the prior concerns have been documented via a Grievance Form, discussed at the next Resident Council Meeting and the person presenting the follow-up to concerns is documented via the Resident Council Meeting form. The Quality Improvement Coordinator will take concerns voiced at Resident Council Meetings and Responses to QAPI monthly until compliance maintained. Element #5 Date of compliance 10/01/2024	

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F 565	Continued From page 4	F 565		

to the 05/16/24 Resident Council meeting minutes noted a resolution that the bird house would be relocated and if there were any more issues with stabilization it would need to be removed and the facility speed limit would be brought up during the monthly staff inservice meetings. The resolution further noted the facility did not allow birdseed and outings to a local park were recommended. The section at the bottom of the form indicating the date the resolution was reported back to the Resident Council and by whom was left blank.

g. The Resident Council meeting minutes dated 06/20/24 revealed no indication that the minutes from the Resident Council meeting held on 05/16/24 were read, approved, revised and/or resolved. There was also no indication the facility's response to the concerns regarding the bird house and speeding that were voiced during the 05/16/24 meeting was communicated to the Resident Council or documented under Old Business.

h. The Resident Council meeting minutes dated 07/18/24 noted a suggestion was made for residents to be able to feed the birds day old bread once a week.

The Resident Council Response Form attached to the 07/18/24 Resident Council meeting minutes noted a resolution that Maintenance said no to having a bird feeding day as the facility did not allow bird seed/food. The section at the bottom of the form indicating the date the resolution was reported back to the Resident Council and by whom was left blank.

A Resident Council group interview was

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F 565	Continued From page 5	F 565		

conducted on 08/28/24 at 10:00 AM with Resident #10, Resident #35, Resident #36, and Resident #65 in attendance. Resident #55 also attended but did not verbally participate in the group interview. Residents #10, #25, #36, and #65 all stated they felt facility staff did not really address their concerns or suggestions because the only response they typically received from staff was "we are working on it", "we are not allowed" or "we can't do that" but never any satisfactory resolution. Resident #36, who was the Resident Council President, added they understood some of the concerns they voiced couldn't be fixed right away but it would be nice to receive communication with "straight answers" as to what was being done. The residents all agreed they would like to know they were being heard and receive feedback from administration on the efforts that had been made or attempted to resolve their concerns and/or suggestions.

During an interview on 08/24/24 at 3:08 PM, the Activity Director (AD) confirmed she attended and recorded the minutes for the Resident Council monthly meetings. The AD explained when residents voiced concerns and/or suggestions during the monthly meetings, she wrote them on a Resident Council Response Form that was then given to the appropriate Department Manager to address. The AD confirmed she did not complete the section on the Resident Council Response Forms to indicate the date resolution was reported back to the Resident Council and explained resolutions to concerns and/or suggestions were typically reported back to the Resident Council at the next scheduled meeting. The AD shared she reviewed the concern with the residents, discussed the resolution and asked the residents if they felt the matter had been

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F 565	Continued From page 6 resolved. She stated if the residents mentioned the same concerns again, she would write it up on another Resident Council Response Form and turn it in to the Administrator to investigate. The former Administrator was unable to be interviewed. During an interview on 08/30/24 at 2:17 PM, the Interim Administrator could not speak to the process of former Administration but did explain when she was the Interim Administrator at the facility previously, she was a fan of Town Hall meetings where they discussed various topics including concerns/suggestions brought up during Resident Council meetings. They also discussed during the meeting what measures the facility had or was doing to address the residents' concerns. The Interim Administrator stated she felt residents were provided verbal communication regarding the facility's response to their concerns but maybe they needed to come up with a plan to communicate the process at each Resident Council meeting to keep it fresh in their minds.	F 565		
F 572 SS=B	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally	F 572		10/1/24

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F 572	Continued From page 7 and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on record review, Resident Council group and staff interviews, the facility failed to provide ongoing communication to residents regarding the rights of residents in a nursing home setting. This occurred for 4 of 5 residents who attended the Resident Council group interview (Residents #10, #35, #36, #55, and #65). Findings included: A review of the Resident Council meeting minutes for 05/11/23 through 08/15/24 revealed no resident rights reviewed section and there was no information noted in the old or new business sections indicating resident rights were reviewed. During a group interview on 08/28/24 at 10:00 AM, Residents #10, #35, #36, and #55 all confirmed they regularly attended Resident Council meetings. Resident #65 stated he was able to walk to the lobby and read the resident rights posted if he wanted but not all residents were able to do so. The residents verified resident rights were not discussed with them during or outside of the Resident Council meetings.	F 572	Element #1 The facility failed to provide ongoing communication to residents regarding the rights of residents in a nursing home setting for residents #10, #35, #55, and #65, who attended the Resident Council group. The Administrator and the Activity Director, or Activity Assistants, will meet with Resident□s #10, #35, #55, and #65 to provide a copy of Resident Rights and to give answer any current questions regarding Resident Rights by 09/30/2024. Element #2 All residents that attend Resident Council are at risk for this deficient practice. All Resident Council meetings will include the review of at least two Resident□s Rights and the Residents will be given the opportunity to ask questions regarding those rights. The Resident Rights reviewed will be documented in the Resident Council meeting notes. Residents who attended Resident Council meetings from 05/11/2023 □ 08/15/2024 audited. Residents who are still present at the facility will be given a copy of the	

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F 572	Continued From page 8 During an interview on 08/30/24 at 12:01 PM, the Activities Director revealed she took over the position in May 2024 and since then, she had facilitated the monthly Resident Council meetings. The Activities Director explained the previous Activities Director reviewed resident rights during the monthly Resident Council meetings; however, she stated she had not been reviewing resident rights during the monthly meetings since she took over the position and did not realize that was something she was supposed to do. During an interview on 08/30/24 at 1:48 PM, the Interim Administrator stated in the facilities she has worked in the past, resident rights were reviewed with residents during the monthly Resident Council meetings. The Administrator stated she would expect for at least 1 to 2 resident rights' to be reviewed with residents during the monthly Resident Council meetings.	F 572	Resident Rights by the Administrator and Activity Director, or Activity Assistants, and an opportunity to ask questions about the Resident Rights by 09/30/2024. Element #3 The Activity Director and Activity Assistants will be educated by the Administrator regarding the Resident Council Meeting policy and presenting Resident Rights by 09/30/2024. Element #4 Resident Council Meetings will be held biweekly x 3 months. The Resident Council President will be interviewed monthly x 6 months to ensure that at the prior Resident Council Meeting at least two Resident Rights are reviewed, and that Residents can ask questions regarding their rights. The Administrator will review the Resident Council Minutes after each meeting to ensure that Resident Rights review is documented x 6 months. The Quality Improvement Coordinator will take Resident Council Minutes to QAPI monthly until compliance is maintained. Element #5 Date of compliance 10/01/2024	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 582		10/1/24

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F 582	Continued From page 9	F 582		

Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

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F 582	Continued From page 10 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABN) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary notification review (Residents #12 and #70). The Findings Included: 1. Resident #12 was admitted to the facility on 12/01/20. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #12's Responsible Party (RP) on 04/02/24 which indicated Resident #12's Medicare Part A coverage for skilled services would end on 04/04/24. Resident #12 remained in the facility. Review of Resident #12's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #12 or Resident #12's RP. During an interview on 08/28/24 at 9:28 AM, the Business Office Manager revealed when a resident's Medicare Part A services were ending, the Minimum Data Set (MDS) Coordinators	F 582	Element #1 The facility failed to provide Skilled Nursing Facility Advanced Beneficiary Notices (SNF ABN) prior to discharge from Medicare Part A skilled services for residents #12 and #70. The Registered Nurse □ Case Mix Director will issue SNF ABNs for residents #12 and #70 by 09/30/2024. Element #2 All residents that were eligible to receive a SNF ABN are at risk for this deficient practice. Residents who were eligible to receive a SNF ABN for the past 6 months will be audited by the Administrator. SNF ABNs will be sent to any eligible residents identified as not having to receive a SNF ABN, by 09/30/2024. Element #3 The Registered Nurse □ Case Mix Director and Registered Nurse □ Case Mix Coordinator were educated by the Administrator regarding Issuing Medicare Beneficiary Notices on 08/29/2024. The completed SNF ABN form will be provided to the Business Office Manager by the Registered Nurse Case Mix Director or	

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F 582	Continued From page 11 forwarded her the NOMNC to review with the resident or their RP and if they did not also send a SNF ABN then one was not issued. The Business Office Manager stated she did not know that both notices were required to be issued when a resident had skilled days left and remained in the facility. The Business Office Manager confirmed a SNF ABN was not issued to Resident #12 or his RP when Medicare Part A skilled services ended on 04/04/24. During an interview on 08/28/24 at 1:54 PM, the Interim Administrator stated she thought the process for issuing the required notices changed which resulted in the issuance of SNF ABN falling through the cracks. The Interim Administrator stated the MDS Coordinators were responsible for forwarding the required NOMNC and SNF-ABN to the Business Office Manager for her to review the notices with the Resident or their RP. 2. Resident #70 was admitted to the facility on 04/01/24. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #70's Responsible Party (RP) on 05/16/24 which indicated Resident #70's Medicare Part A coverage for skilled services would end on 05/20/24. Resident #70 remained in the facility. Review of Resident #70's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #70 or Resident #70's RP. During an interview on 08/28/24 at 9:28 AM, the	F 582	Registered Nurse □ Case Mix Coordinator. The Business Office Manager will issue the SNF ABN to the resident or responsible party for residents who are remaining long-term care in the facility. The Business Office Manager will be educated regarding Issuing Medicare Beneficiary Notices by 09/30/2024 by the Administrator. Element #4 Residents who are eligible to receive SNF ABNs will be audited by the Business Office Manager biweekly x 30 days, then weekly x 30 days, then monthly x 30 days. The Quality Improvement Coordinator will take SNF ABNs to QAPI monthly until compliance is maintained. Element #5 Date of compliance 10/01/2024	

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F 582	Continued From page 12 Business Office Manager revealed when a resident's Medicare Part A services were ending, the Minimum Data Set (MDS) Coordinators forwarded her the NOMNC to review with the resident or their RP and if they did not also send a SNF ABN then one was not issued. The Business Office Manager stated she did not know that both notices were required to be issued when a resident had skilled days left and remained in the facility. The Business Office Manager confirmed a SNF ABN was not issued to Resident #70 or his RP when Medicare Part A skilled services ended on 05/20/24. During an interview on 08/28/24 at 1:54 PM, the Interim Administrator stated she thought the process for issuing the required notices changed which resulted in the issuance of SNF ABN falling through the cracks. The Interim Administrator stated the MDS Coordinators were responsible for forwarding the required NOMNC and SNF-ABN to the Business Office Manager for her to review the notices with the Resident or their RP	F 582		
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.	F 583		10/1/24

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F 583	Continued From page 13 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to protect a resident's right to privacy when Nurse Aide #1 used her cellphone to take an unauthorized video of a resident displaying behaviors and sent the video to Nurse #4 via a cellphone messenger application for 1 of 3 sampled residents (Resident #324). A reasonable person would have experienced embarrassment. Findings included: Resident #324 was admitted to the facility on 10/12/23 with diagnoses that included Alzheimer's disease and dementia with other behavioral disturbance.	F 583	Corrective Action: Nurse Aid #1 received education on 01/05/2024 and Nurse #4 received education on 01/05/2024 regarding Essentials of HIPAA, HIPAA Basics, HIPAA: Do□s and Don□ts of Social Media and Electronic Communication, HIPAA: Privacy Rule. Resident #324 was affected by the video that was taken. This resident has a diagnosis of Neurocognitive DSO with Lewy bodies. He has a BIMs of 0. The video that was taken has been deleted from both employees□ personal cell	

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F 583	Continued From page 14 The admission Minimum Data Set (MDS) dated 10/20/23 revealed Resident #324 had severe cognitive impairment. Review of a Facility Reported Incident (FRI) dated 12/28/23 revealed the facility was made aware on 12/28/23 (no time listed) that Nurse Aide #1 had used her cellphone to take a video of Resident #324 displaying inappropriate behaviors with a Santa Claus mannequin (Christmas decoration). Review of the facility's investigation file revealed an undated typed summary of the investigation signed by the former Director of Nursing (DON) that revealed on 12/28/23 at 9:05 AM, the DON was made aware NA #1 had a video on her cellphone of Resident #324 displaying inappropriate behaviors with a Santa Claus mannequin. The investigation summary revealed both NA #1 and Nurse #4 confirmed that NA #1 had taken a video of Resident #324 and sent it to Nurse #4 via a cellphone messenger application. NA #1 told the former DON that Nurse #4 was not on the unit at the time of the incident and she (NA #1) sent the video "for clinical purposes to demonstrate [Resident #324's] behavior." Both NA #1 and Nurse #4 were suspended pending an investigation. The investigation summary noted all staff were educated on HIPPA (Health Insurance Portability and Accountability Act), residents' rights and the facility's cellphone policy with an emphasis on not using cellphones to take pictures or videos of residents under any circumstances. During a telephone interview on 08/28/24 at 4:38 PM, NA #1 confirmed that she had been assigned to the memory care unit where Resident #324	F 583	phones. Corrective Action for other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by unauthorized video usage. Facility walk through done by Director of Health Care Services (DHS) on 9/16/24 and no partners were noted to have any personal electronic device in resident care area. Systemic changes made to ensure that the deficient practice will not recur: All staff, to include licensed nurses, certified nurses assistants, maintenance, environmental services, dietary, therapy, social services, business office, administrative staff, will be educated on Protecting Patient Privacy and Prohibiting Mental Abuse related to Photographs and Audio or Video Recordings by Partners and on Electronic Devices: Cell Phone Policy. Education was started on 9/16/24 and will be completed by the Director of Healthcare Services (DHS), Assistant Director of Healthcare Services (ADHS) and Clinical Competency Coordinator (CCC). Any staff on FMLA or paid time off will be educated prior to returning to work. The facility does not utilize agency staff. This education was added on 09/17/2024 to the new hire orientation.	

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F 583	Continued From page 15 resided on 12/28/23 during the hours of 6:00 PM to 6:00 AM. NA #1 recalled it was late at night, sometime between midnight and 1:00 AM, when Resident #324 had walked out to the lobby of the memory care unit and picked up a Santa Claus mannequin that was approximately 2-3 feet in height. He then cradled the mannequin in his arms, started rocking his arms back and forth and then kissed the mannequin on top of the head in a tender and affectionate sort of way. NA #1 stated Resident #324 frequently displayed aggressive behaviors and this was a side of him she had not seen before. NA #1 explained Nurse #4 was off the memory care unit at the time and she made the "poor decision" to use her personal cellphone to take a video and send it to Nurse #4 via a cellphone messenger application so that Nurse #4 could see the behaviors Resident #324 was displaying. NA #1 explained that she and Nurse #4 used the cellphone messenger application to communicate with one another and in that moment, she hadn't thought anything about maintaining Resident #324's privacy. NA #1 verified she was aware of the facility's policy regarding cellphone use and restated she made a poor decision and knew better than to take an unauthorized video of a resident. NA #1 she only sent the video to Nurse #4, it was not posted on social media for others to see, and the video was deleted from her cellphone. During a telephone interview on 08/28/24 at 5:37 PM, Nurse #4 confirmed she received a video from NA #1 on her personal cellphone via a cellphone messenger application of Resident #324 on 12/28/23. Nurse #4 stated NA #1 was not being malicious (intending to do harm) in any way and only took the video of Resident #324 because she (NA #1) wanted to show Nurse #4	F 583	Plans to monitor its performance to make sure that the solutions are sustained: Audits for monitoring the use of personal electronic devices in resident care areas and scenario-based questions for the partners will be completed with three residents, five times a week, for 4 weeks, then three residents three times a week for 4 weeks and then three residents one time a week for 4 weeks. The DHS and/or licensed nurse will perform the audits. The Quality Improvement Coordinator will track and trend the audits weekly and bring to the Quality Assurance Performance Improvement monthly until compliant. Date of Compliance: 10/01/2024	

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what was thought to have been a possible behavior. Nurse #4 stated the video of Resident #324 was not sexual in nature at all, he was cradling the Santa Claus mannequin in his arms like a baby, giving it kisses and at one point, it looked like he was dancing with the mannequin. Nurse #4 stated no one else but she and NA #1 saw the video, there was never any intent to post the video on social media and the video was deleted from the cellphone messenger application. Nurse #4 verified she was aware of the facility's policy regarding cellphone use. She stated both she and NA #1 wrong and the video of Resident #324 should have never been taken.

During a telephone interview on 08/29/24 at 12:31 PM, the former DON confirmed it was the facility's cellphone policy that staff should never take photographs or make audio/video recordings of residents residing in the facility using a cellphone. The DON recalled on 12/28/23 he was informed by a staff member (could not recall who) that they had overhead NA #1 talking about a video she had of Resident #324 "making out a with Santa Claus mannequin." The former DON spoke with NA #1 who confirmed she had made the video, sent it to Nurse #4 via a cellphone messenger application and Nurse #4 confirmed she had received the video from NA #1. The former DON recalled NA #1 stating she only took the video to show Nurse #4 Resident #324's behavior and there was never any intent to show the video to others or post on social media. He stated both NA #1 and Nurse #4 were immediately suspended and an investigation initiated which included reporting the incident to the State Agency and the facility's Ethic Committee. The former DON stated the facility's investigation concluded there was no malintent (negative or

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F 583	Continued From page 17 harmful intentions) by either NA #1 or Nurse #4 when the video was made of Resident #324's behaviors. Prior to returning to work, the former DON stated he made sure both NA #1 and Nurse #4 understood it was inappropriate to video residents and they both had to show evidence the video was deleted off their cellphones, cellphone messenger application and complete HIPPA training. The Administrator at the time of this incident was unable to be interviewed. During an interview on 08/30/24 at 1:48 PM, the Interim Administrator stated communication regarding residents should be shared verbally between facility staff and it was never acceptable to take a video of a resident.	F 583		
F 600 SS=G	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:	F 600		

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F 600	Continued From page 18 Based on record review, observations, and interviews with staff the facility failed to protect a resident's right to be free from abuse (Resident #33) when a resident (Resident #324) physically pulled him to the floor causing a fall. During a second physical altercation Resident #324 grabbed hold of Resident #33 causing him to fall on his left hip. After the second fall Resident #33 was unable to move his left leg, complained of pain to the leg and hip, and was transferred to the hospital. The hospital x-ray identified an acute left femoral neck fracture (a break of the upper leg bone just below the joint that connects to the hip) with mild varus angulation (a displacement of the bone causing it to tilt inward towards the midline of the body). The hospital records revealed without surgical repair Resident #33 would be non-weightbearing and bed bound, and the decision was made to perform a surgical repair hemiarthroplasty (a prosthetic replacement of upper leg bone that connects to the hip). A reasonable person would have experienced fear, emotional distress, and pain by being physically abused in their home. The deficient practice resulted for 1 of 3 residents reviewed for abuse. Findings included: Resident #324 was admitted to the facility on 10/12/23 with diagnosis including neurocognitive disorder with Lewy bodies (a brain disorder that affects thinking movement, behavior, mood, and other body functions), Alzheimer's disease, and dementia. The care plan initiated on 10/12/23 included focus problems areas for Resident #324's behavioral symptoms that required admission to the memory support unit related to dementia with behaviors,	F 600	Past noncompliance: no plan of correction required.	

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Lewy body dementia, Alzheimer's, a history of wandering and exit seeking behaviors. The goals included care was provided with dignity minimizing risk for injury and encourage easy transition to the unit as evidenced by acceptance of care, lack of injury, and participation in activities on the unit through the next review. Interventions included orient to memory care unit, room, anticipate and meet all activities of daily living care needs, and provide assistance as appropriate.

The admission Minimum Data Set (MDS) assessment dated 10/20/23 revealed Resident #324's cognition was severely impaired, and he demonstrated physical and verbal behaviors directed towards others for 1 to 3 days during the review period. He was independent with transfers and walking, did not use a device for mobility, and did not fall since admission.

Resident #33 was admitted to the facility on 11/06/23 with diagnoses including Alzheimer's disease, dementia, osteoporosis, and macular degeneration.

The care plan initiated on 11/07/23 included problem focus areas for Resident #33's diagnoses of cognitive loss and dementia that required admission to the memory support unit and being at risk for falls related to dementia with behaviors, agitation, medications, and impaired mobility. The goals included not to sustain injury and/or serious injury, provide care with dignity and minimize risk for injury, encourage easy transition to unit as evidence by acceptance of care and lack of injury through the next review. Interventions included cue for safety awareness, redirect when entering an unsafe area, and

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approach in a calm, friendly and non-threatening manner.

The admission MDS assessment dated 11/13/23 revealed Resident #33's cognition was severely impaired and physical and verbal behaviors directed towards others and wandering had occurred 1 to 3 days during the review period. He required supervision with transfers and walking, had no range of motion impairment, and used a walker for mobility. The MDS indicated Resident #33 had no falls since admission and there had been no recent surgery and no major joint replacement or orthopedic surgery.

Review of the nurse progress note written on 11/16/23 at 10:54 PM revealed Resident #33 had got out of bed and was lost and screaming hello in the hallway. He was given a snack and juice and sat with the nurse and Nurse Aide (NA). He was calm for approximately 15 minutes then begun to scream and tried to get close to the face of the NA and his anger and aggressive behavior was unpredictable.

Review of the progress note written by Nurse #5 on 11/18/23 at 4:28 AM revealed Resident #324 was wandering around the unit earlier with no aggressive behaviors and went to bed around 11:30 PM for a few hours then got back up for a while then went back to bed.

A progress note for the date and time of 11/18/23 at 5:50 AM was documented as a late entry on 11/19/23 at 6:51 AM by Nurse #5. The note read in part, "Nurse #5 was called down the hall for assistance and noted Resident #33 laying on the floor on his left side with his walker in front of him and two NA staff at his side. Resident #33 was

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able to move all extremities except the left lower and was guarding it. When asked by Nurse #5 Resident #33 stated he could not straighten his left leg and complained of pain to the leg and hip and repeated, "He picked me up like a rag doll and threw me." Nurse #6 called the on-call Nurse Practitioner and the ambulance to send Resident #33 to the emergency room for evaluation and treatment as indicated."

Review of the fall event report dated 11/18/23 at 5:55 AM documented by Nurse #5 indicated an unwitnessed fall occurred in the hallway and Resident #33 exhibited pain in the left hip with limited range of motion in the lower extremity and a rotation deformity/shortening of the left lower extremity and a skin tear to the right ear.

During a phone interview on 08/29/24 at 1:35 PM Nurse #5 revealed she was in the office at the nurse station near the 100 living room charting when the NA called for her. She observed Resident #33 on the floor (on the far end of unit). She did not recall any reports related to behaviors from staff involving Resident #33 or #324 during her shift and did not recall the last time she saw them. If she was made aware of any behaviors between them she would have watched and kept track of where the residents were and kept them apart from each other. She described residents on the dementia unit wander, and some got up early and she thought that was what happened when the altercations occurred. She did not watch the video camera footage and revealed she had worked on 11/18/23 to fill in the shift. She described her assessment of Resident #33 revealed he was not able to move his leg and had pain and the fall occurred close to shift change and the day shift Nurse #6 helped with sending

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him to the hospital. She did observe Resident #324 after the incident happened and stated he was walking around with no change in his condition.

Review of the progress note written by Nurse #6 on 11/18/23 at 6:10 AM read in part, "Night shift reported Resident #33 fell and stated he was pushed. Resident #33 made the comment, "He just picked me up and threw me down like a ragdoll." There was another resident sitting in the living area below the hallway where Resident #33 was, and they were separated."

A progress note written by Nurse #6 on 11/18/24 at 6:24 AM read in part, "Resident #33 continued to state he was pushed down by another resident and made the comment several times, "He just picked me up and threw me around like I wasn't nothing."

During an interview on 08/28/24 at 11:04 AM Nurse #6 revealed she reviewed the video camera footage and described she saw Resident #33 and Resident #324 on the far end of the unit around 200 living room with no staff around. Resident #324 was sitting in a chair when Resident #33 used his walker to bump the chair, and it appeared he did it on purpose more than 1 time. She then saw Resident #324 stand up and physically throw Resident #33 to the floor. Resident #33 got himself off the floor, got his walker, and stayed in the 200 living room area but Resident #324 left. Then Resident #33 went around the corner onto the hallway in front of the soiled utility room and rammed his walker into the door several times. Resident #324 came back to where Resident #33 was and put his hands on Resident #33 and the walker was behind and off

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to the side of Resident #33. She stated when Resident #324 put his hands on Resident #33 he went backwards, and it appeared he tripped over the wheel of walker. Nurse #6 revealed at the time of the fall she did ask Resident #324 what happened, but he was not able to articulate and did not recall anything. She revealed Resident #324 was ambulatory and described he was not always easy to redirect and could become aggressive towards staff but to her knowledge not with other residents. He tried to help staff with other residents and when redirected would raise his voice or attempt to hit, he struggled with sleep, and had sundowning behaviors (increased confusion, agitation, and restlessness). She described Resident #33 dementia was not as advanced and he did say to staff. "He threw me around like a ragdoll and picked me up like nothing" several times. She described Resident #33 behaviors he would yell out a lot, be aggressive towards staff during care and verbally aggressive towards other residents by saying shut up or move but she did not recall him being physically aggressive towards other residents.

Review of the initial 24 hour report revealed the facility became aware of the incident on 11/18/2023 at 6:45 AM. The facility self-reported to the state agency on 11/18/23 at 8:32 AM an allegation of abuse based on the statement made by Resident #33, "He pushed me" as he pointed at Resident #324.

Review of the 5-day investigation report revealed the former Administrator completed the investigation and noted there were no witnesses but after review of the facility's video camera footage two back to back physical altercations were observed between Resident #33 and

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Resident #324. The summary of the investigation read in part, "Resident #33 bumped his walker into the chair of Resident #324 twice and it appeared intentional. Resident #324 then pulled Resident #33 to his back and walked away. Resident #33 did not appear injured and got up and walked away. Resident #33 begun to bang his walker into a door and was approached by Resident #324. Resident #324 tripped over the wheel of the walker and tried to catch himself causing Resident #33 to fall on his left hip." The report indicated the incident resulted in physical harm from the second fall when Resident #33 was reported to have a left hip fracture and resulted in serious bodily injury and the allegation of abuse was substantiated.

Review of the statement written by NA #3 read in part, "On the morning of 11/18/23 I was charting when me and my partner heard a resident screaming for help, we got up walked towards Resident #33 and found him on the floor. When asked what happened Resident #33 stated another resident hit him and threw him on the ground and he had pain to his left hip. Me and NA #4 asked Resident #324 if he hit Resident #33 and he stated yes but he hit me as well. Prior to the altercation Resident #33 had been redirected away from Resident #324 because he would agitate him with words and while asleep in the common living room and would try to wake him or run over his feet with his walker or scream while other residents were sleeping."

During a phone interview on 08/28/24 at 2:12 PM NA #3 described Resident #33's behaviors included he used his walker to run over residents' feet and would say mean stuff like, "It doesn't matter I can do whatever I want." She revealed

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Resident #324 was calm and she had not witnessed any type of behavior from him and during her shift on 11/18/23 and he had been up walking around and mostly stayed in the 100 living room area. She revealed on 11/18/23 she witnessed Resident #33 use his walker to run over Resident #324's feet while he was sitting in a chair. She redirected Resident #33 and told him to quit and sat with him and explained Resident #324 was going to get mad. From what she recalled Resident #33 was assisted to bed and she had done a round with NA #4, and she was charting in the 100 living room area (out of sight of 200 living room). It was approximately 45 minutes later she heard Resident #33 yell for help and found him on the floor at the 200 rooms on the far end of the unit. Resident #33 and #324 were the only two residents out of bed at that time and when she asked what happened Resident #33 pointed at Resident #324 and stated, "He slammed me on the floor." Resident #324 was asked what happened, and he looked at Resident #33 and stated, "I slammed him on the floor." NA #3 revealed she did not watch the video camera footage but Resident #33 and #324 were the only two up at the time of the fall. She stated residents were redirected to prevent altercations, but normally she did not work on the memory care/dementia unit and described most need 2-person assist making it hard to track where residents were when 2 NA staff worked.

Review of the statement written by NA #4 read in part, "Around 5:45 AM she was charting in the 100 living room area when she heard resident #33 yell out. I saw Resident #33 lying on the floor in the hallway on opposite end of the unit near the living room area (200 living room). Resident #33 stated, "The guy picked him up like he was

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nothing and hit him and broke his glasses." Resident #324 had the glasses in his possession and appeared to be agitated and uncooperative when I tried to get them from him. Resident #33 complained of severe leg pain and when touched yelled and winced in pain."

During a phone interview on 08/29/24 at 4:30 PM NA #4 revealed her, and NA #3 were charting at the table in the 100 living room area located at front end of the memory support unit and Nurse #5 was in the nurse station located by 100 living room when the altercations occurred. She stated she never saw Resident #324 put his hands on Resident #33 and thought Resident #33 was in his room. She and NA #3 had just done rounds and found Resident #33 getting out of bed, so they got him up and dressed and left him sitting in his room by the 200 living room area. She described Resident #33 was ambulatory and used a walker and Resident #324 walked independently and got around easily. She did not witness the falls and revealed the area where nursing staff were they could not see residents on the far side of unit when in the 200 living room. She did hear Resident #33 yell out and stated the second fall happened by the soiled utility room where the 200 rooms were located. She described Resident #33 was on the ground with his walker on top of him and Resident #324 had the glasses in his back pocket. She asked Resident #33 what happened, and he said he threw me down and pointed at Resident #324. She asked Resident #324 if he threw Resident #33 down and he said no and walked away. She revealed earlier that night Resident #324 was pacing but she did not witness him be aggressive or irritable and Resident #33 had slept good. She did not observe Resident #33 use his walker to

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bump into Resident #324. She revealed Resident #324 did have history of aggressive behaviors towards staff but not residents and she did not know of any aggressive behaviors from Resident #33. Prior to fall Resident #324 sat in the 200 hall living room and been up most of the night but did not recall Resident #33 being out of his room after they got him out of bed. She revealed her and NA #3 had just done a round around 5:00 or 5:15 AM and checked every resident.

During a phone interview on 08/29/24 at 11:05 AM the former Administer stated he was notified early in the morning on 11/18/23 Resident #33 had fallen, and he came to the facility to investigate. After watching the video, he reported the incident to the state agency due to it appeared the second fall happened because Resident #33 was pushed. He stated the falls were unwitnessed and named the former Director of Nursing (DON) and Nurse #6 had also watched the video footage. He stated initially they thought the second fall happened because Resident #324 pushed Resident #33 but after the video was slowed down, he saw Resident #324's foot get caught in wheel of Resident #33's walker. He revealed it was clear the residents were having some kind on disagreement and described the first physical altercation occurred when Resident #33 nudged either the table or chair of Resident #324 and he got up and pushed Resident #33 causing him to fall to the floor and his glasses to come off. He saw Resident #324 pick the glasses up off the floor after the first altercation. After that Resident #33 started banging his walker into the wall and that got Resident #324's attention and he walked down the hallway towards Resident #33. Resident #33 started to use his walker to make a swooping motion and Resident #324's

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foot got tangled in the wheel of the walker. Resident #324 started to fall and when he tried to catch himself, he reached and grabbed Resident #33's shoulder and that's when Resident #33 fell and landed on his hip. Resident #33 did not get up and was sent to the hospital on 11/18/23. Resident #324 was sent to the hospital on 11/18/23 for a psych evaluation and cleared he was not a danger to himself, or others and they could not keep him. When Resident #324 returned to facility he was placed on 1:1 observation until the provider saw him. He revealed after the incident it was his last week as the Administrator at the facility and he did not recall all the corrective actions put in place, but did speak about the plan with his replacement and passed everything off him.

During an interview on 08/30/24 at 2:34 PM the former DON recalled what he observed on the video footage was Resident #324 sitting in a chair in the 200 living room area located in the back of the unit where the first physical altercation occurred. He revealed Resident #33 used his walker to nudge Resident #324 and Resident #324 got up and wrapped his arms around Resident #33 and pulled him to the floor. Resident #324 then walked away and out of view of the camera and the opposite way where Resident #33 was. Resident #33 got up and walked approximately 25 to 35 feet to the 200 hallway and slammed his walker into wall. Resident #324 came back in view of the camera and went to Resident #33. He put his hands on Resident #33 and the two residents started to wrestle each other by putting their hands on each other's arms and hitting one another. They disengaged but stood together and then started again and it appeared Resident #324 lost his

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balance and he could not recall who tripped over the walker, and stated Resident #33 fell and he did not observe staff during the two altercations.

During an interview on 08/28/24 at 1:54 PM the Interim Administrator revealed she was not in her position when the altercations occurred. She revealed the facility no longer had the video camera footage available to view. To her knowledge no request was made to save it and if not, the footage was only kept for 90 days.

During an interview on 08/30/24 at 11:03 AM the Director of Nursing revealed she was not in her position when Resident #33 fell on 11/18/23. She read the facility's incident report that described what happened during both physical altercations between Resident #33 and Resident #324. The DON stated if a staff member had been monitoring the 200 living area on the end of unit where the first altercation started and fall occurred, they would have been aware of Resident #33's behaviors and him agitating Resident #324 and be on alert to monitor the residents. The DON stated she considered the second fall and/or physical altercation was avoidable.

During an interview on 08/30/24 at 1:42 PM the Interim Administrator stated it was her preference that staff be throughout the unit to monitor residents and there was a possibility the second fall and/or physical altercation could have been avoided.

The facility provided the following corrective action plan with the correction date of 11/30/23:

Address how corrective action will be

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accomplished for those residents found to have been affected by the deficient practice.

On 11/28 resident #33 was sent to the hospital for evaluation. Resident #324 was placed on 1:1 supervision and sent out to the hospital for psychiatric evaluation. Set #324 was placed back on 1:1 Supervision upon return to the facility on 11/19/23 until cleared by multiple providers.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

A 100% audit on mobile residents who resided on the unit was conducted on 11/22/23 by the administrator to determine who could be at risk for an altercation that result in a fall. The determination was that the risk was moderate.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

By 11:59 PM on 11/27/23 a 100% of staff will be educated on the abuse policies and procedures and deescalating techniques by the administrator designated person. Those who have not been educated will be removed from the schedule until reviewing the education. On 11/27/23 the systemic change that occurred was putting a gradual dose reduction (GDR) binder in place at each nurse's station which would include the current GDRs and resident care profiles with behavioral care plan approaches.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

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By 11/29/23 the Interdisciplinary Team (IDT) will have compiled a list of GDRs for the facility. The IDT team will review these residents and their progress weekly in the IDT meeting, to offer person-center care approaches for any noted behaviors. The Administrator will audit compliance weekly for 12 weeks. The facility's quality assurance performance improvement (QAPI) committee will discuss and audit the findings and offer recommendations regarding the plan.

Alleged date of compliance: 11/30/23.

The facility's corrective action plan with a completion date of 11/30/23 was validated from 08/28/24 and 09/05/24 by record review, observations and staff interviews.

Resident #33's medical records revealed he was sent to the hospital on 11/18/23 where he received surgical repair for a femoral neck fracture.

Review of the 1:1 monitoring tool of Resident #324 started on 11/19/23 and continued through 11/20/23 and was signed by staff to indicate it was done. QAPI meeting held on 11/20/23 and continued to meet monthly for review.

Review of the Nurse Practitioner progress note dated 11/20/23 revealed Resident #324 was evaluated for dementia with behaviors. After review the NP determined Resident #324 did not seem to be a threat to himself or others and did not need 1:1 observation.

An audit of mobile residents was completed on

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11/22/23 and included review of the previous three months of progress for behaviors, the actions taken by staff, and if the provider and responsible party were notified.

Review of the in-service education date 11/21/23 titled, "Mandatory Abuse Education" reviewed of the facility's abuse policy and procedure for investigation of patient abuse, prevention of patient abuse, and review for deescalating behavior techniques. The training included the procedures to identify, correct, and intervene in situations in which abuse may occur and with analysis to included: supervision of staff to identify inappropriate behaviors, deescalating behavioral symptoms, positive approach techniques, and actions to take. The in-service attendance record was signed by department staff including dietary, administrative, nursing, activities, therapy. Attendance was compared to the current list of employees and started on 11/21/23.

Review of GDR binder located at the nurse stations contained: pharmacy reviews, medication orders, and GDR recommendations. The binder also included the resident's care profile and person-centered behavior care plan with approaches including redirection distraction, interventions, and triggers related to behavior symptoms with updated approaches.

Review of the monitoring tools of residents titled, "Behavior Management Program" started 11/2023 and continued weekly through 02/2024. Staff interviewed were able to verbalize abuse policy and procedure to identify, correct, intervene abuse and to identify inappropriate behaviors, deescalating behavioral symptoms, positive

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F 600	Continued From page 33 approach techniques, and actions to take. Observations of the memory support unit revealed staff were engaging and attentive to the residents and used calm and caring approaches to redirect and deescalate potential behaviors and conflict. The completion date of 11/30/23 was validated.	F 600		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Wound Care Nurse Practitioner (NP) and staff the facility failed to obtain an x-ray as ordered by the Wound Care NP to rule out a possible fracture and osteomyelitis (an infection of the bone) for 1 of 2 residents reviewed for non-pressure skin conditions (Resident #7). Findings included: Resident #7 was admitted to the facility on 01/16/24. His diagnoses included peripheral vascular disease, cellulitis (a bacterial skin infection) of the right toe, and heart failure.	F 684	Corrective Action for the residents found to be affected by the deficient practice: Resident #7 received a right foot x-ray on 8/29/24 to rule out osteomyelitis or fracture. X-ray reveals swelling without fracture or osteomyelitis. Corrective action for other residents having potential to be affected by the same deficient practice: All residents have potential to be affected who are seen by wound care nurse practitioner for incomplete order.	10/1/24

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F 684	Continued From page 34 The quarterly Minimum Data Set (MDS) assessment dated 07/11/24 revealed resident #7 cognition was severely impaired with no rejection of care behaviors. Review of the nurse's progress note dated 08/18/24 revealed it was communicated to the provider Resident #7s right foot appeared with increased tenderness when touched during dressings changes and care. Review of the Nurse Practitioner (NP) progress note dated 08/19/24 revealed Resident #7 was evaluated for right foot tenderness with increased redness involving two lesions on great toe and second toe and swelling to all toes throughout the right foot. The NP note indicated she verbalized to the Wound Care Nurse to order a wound care specialist referral to follow and treat the wounds. The care plan revised on 08/19/24 identified Resident #7 was at risk for new or worsening skin breakdown related to impaired mobility, medications, and non-compliance elevating his lower extremities with antibiotic orders on 08/19/24 related to right toe cellulitis. The goal was for skin breakdown to show evidence of healing and be free of infection through the next review. Interventions included observe the skin with routine care and report any concerns to the nurse. Review of a nurse progress note dated 08/20/24 revealed a late entry was made on 08/21/24. The	F 684	100% audit of the last 3 months of residents seen by wound care practitioner was completed on 8/29/2024 by the Quality Improvement Coordinator and resident #7 was the only incomplete order. Wound care practitioner received education on 9/10/2024 for processing radiology orders. Wound care practitioner received education on 9/10/2024 for processing radiology orders by Registered Nurse Treatment Nurse. Systemic changes made to ensure that the deficient practice will not recur. All licensed nursing staff will receive education on the process of completing physician orders that are ordered by the wound care provider. Education was started on 9/16/2024 and completed by the Director of Healthcare Services (DHS), Assistant Director of Healthcare Services (ADHS), Clinical Competency Coordinator (CCC) and Quality Improvement Coordinator. Any staff on FMLA or paid time off will be educated prior to returning to work. The facility does not utilize agency staff. Plans to monitor its performance to make sure that the solutions are sustained. Wound care provider physician orders will be auditing weekly post visit to ensure orders have been placed in electronic	

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F 684	Continued From page 35 note included wound care treatments and indicated an order was placed for an x-ray to the right foot to evaluate for a fracture and osteomyelitis. The note was electronically signed by the Wound Care NP on 08/21/24. The note was created and signed by the Wound Care Nurse on 08/21/24. Review of Resident #7's electronic medical records revealed no x-ray results to indicate it was done as ordered by the Wound Care NP on 08/21/24. During an interview on 08/28/24 at 5:47 PM the Director of Nursing (DON) revealed the progress note dated 8/21/24 was transcribed by the Wound Care NP and there was no corresponding physician order that she could find in the resident's medical record. The DON revealed she had access to the x-ray company records and she was unable to find an x-ray of the right foot in their system for Resident #7. She revealed the Wound Care NP transcribes her orders including an order for a x-ray. She revealed she was going to follow up with the Wound Care Nurse who edited the progress note on 08/21/24 to ensure the order was entered by the Wound Care NP. During an interview on 08/29/24 at 1:12 PM the Wound Care Nurse explained the Wound Care NP sent the progress note on 08/21/24. The Wound Care Nurse stated she uploaded the progress note into Resident #7's medical record but she did not check to ensure the x-ray order was in place. She revealed Resident #7 was sent to the hospital on 08/21/24 and when he returned	F 684	health records matched progress notes from wound care providers. The audits will continue until compliance. The DHS and/or licensed nurse will complete these audits. Audits will be completed weekly post wound nurse practitioner visit for 3 months. The DHS and/or licensed nurse will perform the audits. The Quality Improvement Coordinator will track and trend the audits weekly and bring them to the Quality Assurance Performance Improvement monthly until compliant. Date of Compliance: 10/01/2024	

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	345558	A. BUILDING _____ B. WING _____	C 09/05/2024

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F 684	Continued From page 36	F 684		

on 08/22/24 she did not clarify with the Wound Care NP if the x-ray was still needed and stated it got missed.

During a follow up interview on 08/29/24 at 1:59 PM the DON revealed since 08/2024 she had received the Wound Care NP progress notes. She stated it was the Wound Care Nurse who uploaded the progress note, and her responsibility to review the medical record to ensure orders were in place.

During an interview on 08/30/24 at 1:30 PM the Wound Care NP revealed she did not enter the order for Resident #7 because she did not know how enter orders into the system for a diagnostic x-ray. She revealed her progress notes with her recommendations were sent to the Wound Care Nurse and DON for review. She saw Resident #7 on 08/27/24 and assumed the reason there was no x-ray results was because the resident had refused. During her assessment of Resident #7's wounds on 8/27/24 she had no concerns and stated they looked good. The Wound Care NP stated she did want the facility to follow up and implement the order for the x-ray and it was done on 08/29/24 and the results were negative.

Review of the right foot x-ray results for Resident #7 revealed the date of the exam was 08/29/24. The results noted right foot swelling with no fracture or osteomyelitis.

An interview on 08/30/24 at 1:39 PM with the Interim Administrator and DON revealed the

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F 684	Continued From page 37 Administrator expected the Wound Care NP to add the order for Resident #7's x-ray into the medical record. The DON revealed the Wound Care NP had been trained on how to put her orders into the electronic medical record.	F 684		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record reviews, the facility failed to secure zinc oxide ointment for 1 of 1 Resident (Resident #6)	F 761	Corrective action for the resident found to be affected by the deficient practice:	10/1/24

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F 761	Continued From page 38 review for medication storage, failed to remove expired over-the-counter (OTC) medications from the medication cart in accordance with the manufacturer's expiration date, and failed to discard an eye drops from the medication carts as specified by the manufacturer's guidelines for 2 of 3 medication carts (B halls and D halls). The findings included: a. Resident #6 was admitted to the facility on 04/16/24 with diagnoses including dermatitis. A review of Resident #6's medication records revealed he had never been assessed nor approved for self-administration of medication. The quarterly Minimum Data Set (MDS) dated 08/20/24 coded Resident #6 with an intact cognition The physician's orders dated 08/21/24 revealed Resident #6 had an order to receive a thin film of zinc oxide ointment 20% topically to both sides of groin and scrotum twice daily for diaper rashes. During a medication storage observation conducted on 08/26/24 at 4:23 PM, an approximately one inch of unknown white color ointment was observed left unattended in an opened plastic cup sitting on top of Resident #6's table in his room. An interview was conducted with Resident #6 on 08/26/24 at 4:24 PM. He stated the ointment on the table was left by Nurse #1 who had wheeled him back to his room about 5 minutes ago. He explained Nurse #1 planned to apply the ointment for him after returning to his room. However, he	F 761	Over the counter Mucinex and eye drops were immediately removed from the medication cart on 8/27/2024. Zinc oxide was removed immediately from resident #6 room on 8/26/2024. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by expired medications and medications left at bedside. An audit of three medication carts and three medication rooms were completed by licensed nurses on 09/16/2024. No expired medication noted in any areas. Audit of 72 resident rooms focusing on medication at bedside was completed by licensed nurses on 09/19/2024. Eight residents had medications at bedside with seven residents preferring to keep over the counter medication at bedside. Provider notified on 09/20/2024 and Self-Administration of Medication Observation completed for the seven residents 09/20/2024. Systemic changes made to ensure that the deficient practice will not recur. Education for all licensed nurses on medication storage was completed on 8/29/2024. Education for all licensed nurses on bedside medication storage was started on 9/16/2024 and will be completed by the	

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F 761	Continued From page 39 needed to use the bathroom before applying the ointment. When he got out from the bathroom, Nurse #1 was not around, and the ointment was left unattended on the table in his room. During a joint observation with Nurse #1, she confirmed she had left the zinc oxide ointment unattended in Resident #6's room. She explained she initially planned to apply the ointment when she wheeled Resident #6 back to his room. While she was waiting for Resident #6 to use the bathroom, a nearby resident called for help. She was distracted and left the zinc oxide ointment on the table. She acknowledged that she should have taken the ointment with her before leaving the room. b. The manufacturer's package inserts for Latanoprost eye drops revealed an unopened bottle should be stored under refrigeration between the temperature of 36° to 46° Fahrenheit (F) and protected from light. Once it was opened, Latanoprost could be stored at room temperature up to 77° F for up to six weeks. A medication storage audit was conducted on 08/27/24 at 1:04 PM for B halls medication cart in the presence of Nurse #2. One opened bottle of Latanoprost 0.005% eye drops was found in the medication cart under room temperature and ready to be used. The handwriting on the label indicated it was opened on 06/12/24. An interview was conducted on 08/27/24 at 1:06 PM. Nurse #2 explained she did not work at B halls on regular basis. She thought Latanoprost would expire as indicated on the bottle by the manufacturer and did not know that it would expire after it was opened and stored in room	F 761	Director of Healthcare Services (DHS), Assistant Director of Healthcare Services (ADHS), Clinical, Competency Coordinator (CCC) and Quality Improvement Coordinator. Any staff on FMLA or paid time off will be educated prior to returning to work. The facility does not utilize agency staff. Plans to monitor its performance to make sure that the solutions are sustained. Medication cart and medication room audits will be completed four times a week for 3 months. Medication at bedside audits will be completed five times a week for 4 weeks, 3 weeks for 4 weeks and once a week for 4 weeks. The DHS and/or licensed nurse will perform the audits. The Quality Improvement Coordinator will track and trend the audits weekly and bring them to the Quality Assurance Performance Improvement monthly until compliant. Date of Compliance: 10/01/2024	

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F 761	Continued From page 40	F 761		

temperature for 42 days. She acknowledged that the mentioned Latanoprost was expired and should be discarded.

c. During a medication storage audit conducted on 08/27/24 at 1:38 PM for D halls medication cart in the presence of Nurse #3, a used blister card containing 9 tablets of Mucinex 600 milligrams (mg) expired on 07/31/24 were found in the medication cart and ready to be used.

An interview was conducted with Nurse #3 on 08/27/24 at 1:40 PM. She stated the night shift nurse was responsible for checking the medication cart every night and the consultant pharmacist would check the medication carts during her monthly visits. She explained the OTC Mucinex had not been used for a while and acknowledged that they were expired and should be discarded.

During an interview conducted with the Administrator on 08/30/24 at 11:16 AM, she expected all the nursing staff to follow manufacturers' guidelines to discard expired medications in a timely manner and keep the facility free of unattended medications.

An interview was conducted with the Director of Nursing (DON) on 08/30/24 at 11:56 AM. She stated all the nurses were instructed to check their respective medication carts during their shift. She attributed the expired Latanoprost to unclear expiration date written on the label, and low proficiency in medication storage guidelines among nurses. It was her expectation for the nursing staff to follow the manufacturer's storage guidelines and keep the facility free of expired or unattended medications.

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F 812 SS=E	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. (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 observations and staff interviews the facility failed to discard potentially hazardous food with signs of spoilage in 1 of 1 walk-in refrigerators and discard expired food items available for resident use in 1 of 1 walk-in freezers. This practice had the potential to affect food served to residents. Findings included: a. An observation of the walk-in refrigerator on 08/26/24 at 08:58 AM revealed the following: A box containing 2 unopened bags of green leaf lettuce with browning leaves and brown liquid present inside of the bag with a received by the facility date of 7/29/24.	F 812	Element #1 The facility failed to discard potentially hazardous food with signs of spoilage. Two unopened bags of green-leaf lettuce, one box of celery and one box of cinnamon rolls that were out of date or with signs of spoilage discarded on 08/26/2024. None of the potentially hazardous food was used for resident food service and there are no residents that were affected by this adverse practice. Element #2 This deficient practice had the potential of affecting all residents. The walk-in	10/1/24

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F 812	Continued From page 42 A box of celery with a white fuzzy substance on the celery with no visible date was present. b. An observation of the walk-in freezer on 08/26/24 at 09:09 AM revealed the following: An open box of cinnamon rolls with an expiration date of 12/29/22. An interview with the Dietary Manager on 08/26/24 at 09:10 AM revealed that a dietary staff member stocked and checked the walk-in refrigerator and walk-in freezer weekly for expiration dates and spoiled food. He stated that the expired and spoiled items should have been thrown out by dietary staff and it must have been overlooked. An interview with the Interim Administrator on 08/30/24 at 12:01 PM revealed that her expectation was that kitchen food storage adheres to regulatory standards and foods that are expired or moldy are removed from rotation and disposed of.	F 812	refrigerator and freezers will be audited by the Dietary Manager and Registered Dietician by 09/20/2024. None of the potentially hazardous food had been used for resident food service and there are no residents that were affected by this adverse practice. Element #3 All Dietary Personnel will receive education by Registered Dietician regarding food storage policy by 09/30/2024. Element #4 Food stored in Walk-in-Refrigerator and Freezer will be audited five times a week x 4 weeks, then weekly x 8 weeks by the Dietary Manager, Assistant Manager or Registered Dietician by 09/30/2024. The Registered Dietician will audit monthly x 3 months. The Quality Improvement Coordinator will take Food Storage Audits to QAPI monthly until compliance is maintained. Element #5 Date of compliance 10/01/2024	