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	345162	A. BUILDING ______ B. WING ______	C 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	**416 N HIGHLAND STREET GASTONIA, NC 28052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/13/25 through 01/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# M6OO11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/13/25 through 01/17/25. Event ID# M6OO11. The following intakes were investigated: NC00226099, NC00226121, NC00225719, NC00225777, NC00225550. NC00225606, NC00225574, NC00223329, NC00223233, NC00222937, NC00223012, NC00221815, NC00220248, NC00219881, NC00219219, NC00215082, NC00213782, NC00213556, and NC00211448. 3 of the 49 complaint allegations resulted in deficiency.	F 000		
F 582 SS=E	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 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	F 582		2/12/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 582	Continued From page 1 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. (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	F 582	1. The facility failed to provide Notice of Medicare Non-Coverage to resident #57,	

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F 582	Continued From page 2 Advanced Beneficiary Notices (SNF ABN) prior to discharge from Medicare Part A skilled services for 3 of 3 residents reviewed for beneficiary notification review (Residents #57, #90 and #92). The Findings Included: 1. Resident #57 was admitted to the facility on 06/28/24. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #57's Responsible Party (RP) on 08/20/24 which indicated Resident #57's Medicare Part A coverage for skilled services would end on 08/23/24. Resident #57 remained in the facility. Review of Resident #57's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #57 or Resident #57's RP. During an interview on 01/16/25 at 11:16 AM, the Business Office Manager (BOM) revealed she issued SNF ABNs for residents covered under Medicare Part B. She stated the Social Worker (SW) issued NOMNC's and SNF ABNs for residents covered under Medicare Part A. During an interview on 01/16/25 at 11:24 AM, the SW confirmed she was responsible for issuing a NOMNC when a resident's Medicare Part A services were ending. The SW stated she did not know what a SNF ABN was or that she was supposed to issue one when a resident had skilled days left and remained in the facility. The SW confirmed a SNF ABN was not issued to Resident #57 or his RP prior to Medicare Part A	F 582	#90, and #92. Resident #57 continues to reside in the facility receiving skilled nursing care. Resident # 90 was discharge from the facility on 10/11/24. Resident #97 was discharged from the facility on 9/9/24. 2. All residents receiving Medicare Part A skilled services have the potential to be affected by the deficient practice. The administrator, business office manager and Social Worker completed an audit of everyone that is in the facility under Medicare Part A to ensure all Notices of Medicare non-coverage would be given per Center for Medicare and Medicaid Services guidelines (NOMC). 3. The Administrator re-educated the Business Office Manager and the Social Worker on _1/20/25_ regarding the facility policy for issuing NOMNCs to residents prior to discharge from Medicare Part A skilled services. The Business Office Manager will review and audit all NOMNCs to Medicare Part A skilled residents to ensure they are issued in accordance with facility policy prior to discharge from Medicare Part A skilled services. Social Worker will ensure Medicare Part A residents receive Center for Medicare and Medicaid Services and Business Office Manager and/or designee will be backup. New Bushiness office managers/Social workers will be educated of this process upon hire in orientation. 4. The Business Office Manager/ and or	

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F 582	Continued From page 3 skilled services ending on 08/23/24. During an interview on 01/16/25 at 3:00 PM, the Administrator revealed the SW was responsible for issuing a NOMNC and/or SNF ABN to the resident or their RP when Medicare Part A services were ending. The Administrator expressed she had assumed the SW was aware to issue a SNF ABN in addition to a NOMNC when needed. The Administrator stated she would have expected for the SW to have issued both notices to Resident #57 or his RP as required. 2. Resident #90 was admitted to the facility on 11/02/22. Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #90's Responsible Party (RP) on 08/26/24 which indicated Resident #90's Medicare Part A coverage for skilled services would end on 08/28/24. Resident #90 remained in the facility until she discharged home on 10/11/24. Review of Resident #90's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #90 or Resident #90's RP. During an interview on 01/16/25 at 11:16 AM, the Business Office Manager (BOM) revealed she issued SNF ABNs for residents covered under Medicare Part B. She stated the Social Worker (SW) issued NOMNC's and SNF ABNs for residents covered under Medicare Part A. During an interview on 01/16/25 at 11:24 AM, the	F 582	designee will conduct audits to ensure Medicare residents will be provided their notice of Medicare non-coverage 2xs a week for 12 weeks. The Business Office Manger will report the results of these audits monthly for 3 months during the Quality Assurance Performance Improvement committee meeting. The committee will make recommendations as needed to maintain substantial compliance. 5. Date of compliance 2/12/2025	

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SW confirmed she was responsible for issuing a NOMNC when a resident's Medicare Part A services were ending. The SW stated she did not know what a SNF ABN was or that she was supposed to issue one when a resident had skilled days left and remained in the facility. The SW confirmed a SNF ABN was not issued to Resident #90 or her RP prior to Medicare Part A skilled services ending on 08/28/24.

During an interview on 01/16/25 at 3:00 PM, the Administrator revealed the SW was responsible for issuing a NOMNC and/or SNF-ABN to the resident or their RP when Medicare Part A services were ending. The Administrator expressed she had assumed the SW was aware to issue a SNF ABN in addition to a NOMNC when needed. The Administrator stated she would have expected for the SW to have issued both notices to Resident #90 or her RP as required.

3. Resident #92 admitted to the facility on 06/11/24.

Review of a Notice of Medicare Non-Coverage (NOMNC) revealed the notice was discussed with Resident #92 on 08/20/24 which indicated Resident #92's Medicare Part A coverage for skilled services would end on 08/22/24. Resident #92 remained in the facility until he discharged home on 09/09/24.

Review of Resident #92's medical record revealed no evidence a SNF ABN was reviewed with or provided to Resident #92.

During an interview on 01/16/25 at 11:16 AM, the Business Office Manager (BOM) revealed she

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F 582	Continued From page 5 issued SNF ABNs for residents covered under Medicare Part B. She stated the Social Worker (SW) issued NOMNC's and SNF ABNs for residents covered under Medicare Part A. During an interview on 01/16/25 at 11:24 AM, the SW confirmed she was responsible for issuing a NOMNC when a resident's Medicare Part A services were ending. The SW stated she did not know what a SNF ABN was or that she was supposed to issue one when a resident had skilled days left and remained in the facility. The SW confirmed a SNF ABN was not issued to Resident #92 prior to Medicare Part A skilled services ending on 08/22/24. During an interview on 01/16/25 at 3:00 PM, the Administrator revealed the SW was responsible for issuing a NOMNC and/or SNF-ABN to the resident or their RP when Medicare Part A services were ending. The Administrator expressed she had assumed the SW was aware to issue a SNF ABN in addition to a NOMNC when needed. The Administrator stated she would have expected the SW to have issued Resident #92 both notices as required.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		2/12/25

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F 584	Continued From page 6 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain residents' wardrobe closets in good repair by not replacing knobs on the drawers which left exposed screws sticking out from the drawer that had the potential to cut residents when entering and exiting their rooms (rooms 202, 208, 215, 223, and 225); failed to	F 584	1. The facility failed to provide the residents with a safe / clean/ homelike environment. The maintenance director immediately replaced broken knobs on drawers in rooms 202, 208, 215, 223, and 225. The maintenance director immediately fixed/repaired the broken	

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Continued From page 7

ensure a resident's wardrobe closet had functioning drawers (room 212); failed to maintain a clean and sanitary wheelchair (room 227-A); and failed to ensure a call light cover was secured to the wall in a resident's bathroom to prevent it from coming loose when the cord was pulled to engage the call light (room 226) for 8 of 31 rooms on 1 of 2 resident halls (200 hall) reviewed for environment.

The findings included:

1. a. Observations of room #202 on 01/14/25 at 8:44 AM, 01/15/24 at 9:02 AM, and 01/16/25 at 11:00 AM revealed a wardrobe closet located just inside the room door. The bottom drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The bottom drawer was approximately 1 foot from the floor.

b. Observations of room #208 on 01/15/25 at 9:03 AM and 01/16/25 at 11:01 AM revealed a wardrobe closet located just inside the room door. The bottom drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The bottom drawer was approximately 1 foot from the floor.

c. Observations of room #215 on 01/15/25 at 9:05 AM and 01/16/25 at 11:03 AM revealed a wardrobe closet located just inside the room door. The top drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The top drawer was approximately 2 feet from the floor.

F 584

drawers in room 212. The environment services director immediately cleaned the wheelchair in room 227A. The call light cover in room 226 was fixed/repaired immediately.

2. On 1/20/25 the maintenance director completed an audit of ALL residents rooms to identify and repair any broken or missing knobs on wardrobes or dresser drawers. On 1/20/25 the environment services manager gave the administrator a wheelchair cleaning schedule that would be followed weekly. Managers that have been assigned room rounds will discuss any missing knobs on wardrobes or dresser drawers as well as wheelchairs that need to be cleaned during stand up/stand down meeting five days a week to ensure compliance.

3. All staff was educated to use maintenance books on both first and second floor to communicate all maintenance concerns. Maintenance will review the books daily. New hires/agency will be educated in orientation of this process.

4. An Ad-Hoc QAPI meeting was held with the interdisciplinary team on 2/3/25 to discuss this plan.The maintenance director will round 3 times per week for 12 weeks to ensure no knobs are missing on residents dressers and/or drawers and ensure call light covers are in good repair. The environmental service director will round 3 times per week for 12 weeks to ensure floor techs are following the

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F 584	Continued From page 8 d. Observations of room #223 on 01/15/25 at 9:07 AM and 01/16/25 at 11:05 AM revealed a wardrobe closet located just inside the room door. Both the bottom and top drawers on the left side of the wardrobe closet were missing knobs and the end of the screws were sticking out approximately one inch. The top drawer was approximately 2 feet from the floor and the bottom drawer was approximately 1 foot from the floor. e. Observations of room #225 on 01/15/25 at 9:08 AM and 01/16/25 at 11:07 AM revealed a wardrobe closet located just inside the room door. The top drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The top drawer was approximately 2 feet from the floor. f. Observations of room #212 on 01/15/25 at 9:04 AM and 01/16/25 at 11:02 AM revealed a wardrobe closet located just inside the room door. The bottom two drawers had no knobs and both drawers were off track preventing them from opening and closing properly. An environmental tour and interview was conducted on 01/17/25 at 9:39 AM with the Maintenance Director, which revealed the conditions of rooms 202, 208, 212, 215, 223, and 225 remained unchanged. The Maintenance Director acknowledged the exposed screws on the drawers of the wardrobe closets and the drawers not closing properly were safety concerns due to the potential for causing a skin tear or other injury and needed repaired. He explained he had replaced the left 2 knobs on the closet drawers in room 223 last week but was not	F 584	wheelchair cleaning schedule and identifying those that may need additional cleaning. Results of audits will be discussed at the monthly Quality Assurance Improvement meeting for 3 months to ensure substantial compliance is achieved 5. Date of compliance 2/12/2025	

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sure why they were missing now and he was not aware of the missing knobs on the closet drawers in rooms 202, 208, 215 and 225. He explained the bottom 2 wardrobe closet drawers in room 212 were replacements and he had ordered new tracking for them to fit properly. The Maintenance Director stated he and the Department Managers made daily rounds to identify concerns but he also relied on floor staff to notify him when repairs were needed.

During an interview on 01/17/25 at 11:37 AM, the Administrator stated the Department Managers conducted room rounds twice a day and they should be looking at the wardrobe closet drawers to ensure knobs were in place and were working properly. The Administrator stated the issues with the closet drawers in rooms 202, 208, 212, 215, 223 and 225 should have been identified during daily rounds and staff should have informed the Maintenance Director repairs were needed.

2. Observations of the wheelchair in 227-A on 01/15/24 at 9:04 AM and 01/16/25 at 9:59 AM revealed dried, crusty debris on top and underneath the seat cushion and dried debris on the brake of the wheelchair.

During an interview on 01/17/25 at 10:51 AM, the Environmental Services Director revealed her company was new to the facility as of last week and they were currently in the process of developing a schedule for cleaning and disinfecting resident wheelchairs. She stated that some of the resident wheelchairs were washed on Monday (01/13/25) and Tuesday (01/14/25) but she did not have documentation of the specific wheelchairs that were included.

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F 584	Continued From page 10 During an observation and follow-up interview on 01/17/25 at 11:27 AM, the Environmental Services Director confirmed the wheelchair in room 227-A had dried, crusty debris on top and underneath the seat cushion and dried debris on the brake of the wheelchair. She acknowledged the wheelchair needed a good cleaning. The Environmental Services Director stated she was informed by the Administrator during the morning meeting on Monday (01/13/25) that some of the wheelchairs on the 2nd floor, where room 227-A was located, needed to be cleaned but the Administrator had not provided specific room numbers or resident names. During an interview on 01/17/25 at 11:37 AM, the Administrator revealed she was aware of the issue with resident wheelchairs not being cleaned regularly and explained there had been changes in the environmental services department. She stated she provided the Environmental Services Director with a list of resident wheelchairs that needed cleaned, which included the wheelchair in room 227-A, and had also discussed with the Environmental Services Director to ensure the wheelchair in room 227-A was checked daily and cleaned frequently. The Administrator stated she had been working with the Environmental Services Director on a process to ensure resident wheelchairs were cleaned routinely and a cleaning schedule was recently put into place. 3. Observations of the bathroom in room 226 on 01/13/25 at 2:30 PM and 01/16/25 at 8:25 AM revealed when the call light switch was pulled the face plate cover came away from the wall and was not secured in place.	F 584		

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F 584	Continued From page 11 An interview and observation was conducted with the Maintenance Director on 01/17/25 at 9:38 AM. The Maintenance Director observed in room 226 the call light in the bathroom did work when the switch was pulled but the face plate cover came away from the wall and was not secure. The Maintenance Director revealed Department Heads did daily rounds to check for environment issues and he tried to check call lights as part of his daily round. He revealed environment concerns identified were discussed with him during the morning meetings and staff could report concerns to him verbally or fill out a work order. The Maintenance Director stated he was not aware the face plate cover was not secured to the wall in the bathroom of room 226. During an interview on 01/17/25 at 5:32 PM the Administrator revealed Department Heads did daily room rounds to check for environment issues. The Administrator stated she was not aware the call light switch in the bathroom of room 226 was not secured to the wall.	F 584		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		2/12/25

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§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure Registered Nurse (RN) coverage was provided for at least 8 consecutive hours per day for 4 of the 91 days reviewed for RN Coverage (5/04/24, 5/18/24, 5/25/24, and 6/08/24).

Findings included:

The Payroll Based Journal (PBJ) report for third quarter of 2024 (April, May, and June) reported the facility without RN coverage for 8 consecutive hours per day for 5/04/24, 5/18/24, 5/25/24, and 6/08/24.

a. Review of the daily staffing assignment sheet for Saturday, 5/04/24 revealed no RN assigned.

Review of the timecard record for 5/04/24 revealed the former Director of Nursing (DON) had a clock in time of 6:45 AM and a clock out time of 3:15 PM.

An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage.

An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former DON worked 5/04/24. She stated that since the former

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1. The facility failed to ensure that coverage by a Registered Nurse (RN) was provided for 8 consecutive hours for 4 out of 91 days.

2. All residents, visitors and staff have the potential to be affected by the lack of RN coverage. All schedules have been reviewed to ensure the facility does have 8 hours of consecutive RN coverage daily. A Secondary RN backup call schedule has been put into place to ensure the facility has 8 hours of RN coverage daily per Center for Medicare and Medicaid Services guidelines.

3. The Administrator conducted an in-service with staff scheduler which included the regulatory requirement surrounding 8 consecutive hours of RN coverage. Written education was provided to RN Nurse Management regarding on-call scheduling and expectation. Education was completed on 1/21/25. The RN call schedule was implemented 2/10/2025 and only includes RN Nurse Management. Newly hired RN Mangers will be educated on the on-call rotation in orienation.

4.The Administrator or designee will audit the facility staff schedule weekly/daily during labor meeting to ensure that 8

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F 727	Continued From page 13 DON was a salaried employee and did not clock in and out. However, the Administrator added a clock in and out for the former DON to show the facility had RN coverage for 8 consecutive hours per day. An interview on 1/15/25 at 1:02 PM with the former DON revealed she was employed at the facility in May 2024. She stated she had never worked at the facility on the weekend and was not at the facility on 5/04/24. A follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'. b. No daily staffing assignment sheet for Saturday, 5/18/24 was provided by the facility. Review of the timecard record for 5/18/24 revealed no RN had clocked in or out. An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage. An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former Assistant Director of Nursing (ADON) worked 5/18/24. She stated that since the former ADON was a salaried employee and did not clock in or out. The Administrator stated she should have added a clock in and out for the former ADON to show the facility had RN coverage for 8 consecutive hours	F 727	hours of RN coverage is sustained 7 days a week. Audit will continue for one quarter to ensure that compliance is sustained. An Ad-Hoc Quality Assurance Improvement Plan meeting was held 2/3/25 to discuss this plan. Result of audits will be reviewed at the facility□s monthly QAPI meeting for 3 months to ensure that substantial compliance is met. 5. Date of Compliance 2/12/2025	

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Continued From page 14
per day, but she had not. No documentation was provided regarding the ADON working on 5/18/24.

An interview on 1/15/25 at 4:29 PM with the former ADON revealed that she did not recall ever working a weekend day after she became the ADON on 5/01/24.

During a follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'.

c. The facility was unable to provide the daily nurse staffing assignment sheet for Saturday, 5/25/24.

Review of the timecard record for 5/25/24 revealed the former ADON had a clock in time of 6:45 AM and a clock out time of 3:15 PM.

An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage.

An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former ADON worked 5/25/24. She stated that since the former ADON was a salaried employee and did not clock in and out. However, the Administrator had added a clock in and out for the former ADON to show the facility had RN coverage for 8 consecutive hours per day.

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F 727	Continued From page 15	F 727		

An interview on 1/15/25 at 4:29 PM with the former ADON revealed that she did not recall ever working a weekend day after she became the ADON on 5/01/24.

A follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'.

d. No daily staffing assignment sheet for Saturday, 6/08/24 was provided by the facility.

Review of the timecard record for 6/08/24 revealed the former DON had a clock in time of 6:45 AM and a clock out time of 3:15 PM.

An interview on 1/16/25 at 3:54 PM with the Scheduler revealed she was aware of the requirement for RN coverage 8 consecutive hours per day. She stated if there she was unable to schedule an RN, she brought it to the Director of Nursing and Administrator's attention for their assistance to ensure RN coverage.

An interview on 1/14/25 at 5:01 PM with the Administrator revealed that the former DON worked 6/08/24. She stated that since the former DON was a salaried employee and did not clock in and out. However, the Administrator stated she had added a clock in and out for the former DON to show the facility had RN coverage for 8 consecutive hours per day.

An interview on 1/15/25 at 1:02 PM with the former DON revealed she was employed at the facility on 6/08/2024. She stated she had never worked at the facility on the weekend and was not at the facility on 6/08/24.

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During a follow up interview on 1/16/25 at 1:11 PM with the Administrator revealed she felt like the former staff denied being at the facility due to 'disgruntlement'.

F 732 SS=C Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) F 732 2/12/25

§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

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F 732	Continued From page 17 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post complete and accurate daily licensed nurse staffing information for 19 of the 20 days reviewed 5/04/24, 5/18/24, 5/25/24, 6/08/24, and 1/01/25 through 1/16/25 for sufficient staffing and failed to maintain a posted staffing sheets for one day (5/25/24). Findings included: Reviews of posted staffing for 5/04/24, 5/18/24, 5/25/24, 6/08/24, and 1/01/25 through 1/16/25 revealed one day, 1/16/25, had been updated to accurately reflect the staffing. The facility was unable to provide a staffing sheet for 5/25/24. During an interview on 1/14/25 at 5:01 PM with the Scheduler, she stated she was responsible for the staff posting and that she was unaware of the requirement to adjust the posted staffing information to reflect the actual staff present. She stated that she completed the posted staffing sheets ahead of time based on the staff work schedule. She stated when she was off on the weekend or vacation, she completed the posted staffing sheets ahead of time and they were not adjusted to accurately reflect the actual staffing. The Scheduler was unable to locate the posted staffing sheet for 5/25/24.	F 732	1. The facility failed to post complete and accurate daily licensed nurse staffing information for 19 of 20 days and failed to maintain a posted staffing sheet for one day. Facility□s staff scheduler updated staff posting on 1/16/25 to reflect current licensed nurse staffing information. 2. Staff Scheduler updated staffing posting on 1/16/25 to reflect accurate changes. Staff Scheduler and/or designee will ensure all staff postings are updated to reflect changes if needed the beginning of each shift. 3. The Director of Nursing conducted an in-service training session with the Assistant Director of Nursing (ADON), staff scheduler, and Unit Managers regarding the regulatory requirement for posting licensed nurse staffing and maintaining accuracy with any changes to schedule at the beginning of the shift. The training included specific data requirements and the importance of maintaining compliance. This education was completed on 1/21/25. Newly hired Nurse Managers / Staff scheduler will be educated on this process during orienation.	

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F 732	Continued From page 18 During an interview on 1/16/25 at 1:11 PM the Administrator, she stated she was aware of the requirement to adjust the posted staffing to accurately reflect the actual staff present. She also stated she was unaware this was not being done and that the Scheduler did not know that the posted staffing should be updated with the actual staff on each shift.	F 732	4. The Administrator and/or designee will audit the posting of licensed nurse staffing data for each shift 3 times per week for 12 weeks. Audit findings will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months or until substantial compliance is achieved. 5. Date of compliance 2/12/2025	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		2/12/25

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F 756	Continued From page 19 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Consultant Pharmacist interviews, the facility failed to follow the pharmacy recommendation to update a medication order to include indication for use for 1 of 5 residents reviewed for unnecessary medications (Residents #77). Findings included: Resident #77 admitted to the facility on 06/17/24 with diagnoses that included dementia, mood disturbance, anxiety disorder and major depressive disorder. An active physician's order dated 08/23/24 for Resident #77 read, Lamotrigine (mood stabilizer) 25 milligrams (mg) - "give one tablet by mouth two times a day for.." There was no diagnosis included on the order indicating reason for use. The significant change Minimum Data Set (MDS) assessment dated 08/29/24 revealed Resident #77 had severe impairment in cognition.	F 756	1. The facility failed to follow the pharmacy recommendation for resident #77 when a medication indication was not updated. Director of Nursing updated order to reflect indication for use on 1/16/25. 2. All residents have the potential to be affected by the deficient practice. Audit was completed on 1/22/25 by the Director of Nursing on all pharmacy recommendations for past 90 days to ensure all recommendations were completed. No other incomplete recommendations were noted during the audit. 3. Education was provided to all licensed nursing staff, including agency by the Director of Nursing (DON) and Unit Manager. Education included ensuring that monthly pharmacy recommendations are completed thoroughly as well as ensuring medications have indication for	

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Review of a "Pharmacist's Recommendation to Prescriber" form dated 10/31/24 read, Resident #77 "has an order for Lamotrigine 25 mg - give one tablet by mouth two times a day for.. Please update order directions to include indication for use." The bottom of the form where the provider would agree or disagree, provide comments and sign the form was blank.

The Medication Administration Records (MARs) for October 2024, November 2024, December 2024, and January 2025 revealed Resident #77 received Lamotrigine 25 mg twice daily as ordered.

During a phone interview on 01/16/25 at 2:03 PM, the Consultant Pharmacist revealed as part of her monthly medication reviews, she checked to ensure medications had a clinical indication for use and if they did not, she submitted a recommendation to the facility. She confirmed that she submitted a recommendation to the facility on 10/31/24 to add an indication of use to Resident #77's Lamotrigine medication order. She explained she was out of work November 2024 and December 2024 and the Pharmacists who covered in her absence likely had not known to follow up on the recommendation. The Consultant Pharmacist indicated it was her expectation for the facility to have addressed the recommendation for Resident #77 within 30 days, before the next monthly medication review.

During an interview on 01/16/25 at 11:55 AM, the Director of Nursing (DON) revealed she had started back at the facility in December 2024 and since then, the Unit Manager was the person responsible for reviewing and following-up on pharmacy recommendations and then sending

F 756 (Plan of Correction)

use when obtaining orders. Education was completed 1/30/25. Licensed nurses on leave will be educated prior to next scheduled shift. New licensed nurses and agency nursing staff will be educated during the orientation process.

4. An Ad-Hoc QAPI meeting was held with the interdisciplinary team on 2/3/25 to discuss this plan. Audits will be conducted by the Director of Nursing/Designee of all pharmacy recommendations monthly for 3 months to ensure all recommendations are completed. Results of audits will be discussed at the monthly Quality Assurance Improvement meeting for 3 months to ensure substantial compliance is achieved.

5. Date of completion 2/12/2025

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F 756	Continued From page 21 them back to her when completed. The DON stated prior to December 2024, she was not sure who was following-up on pharmacy recommendations. The DON confirmed the pharmacy recommendation dated 10/31/24 for Resident #77 had not been addressed and a diagnosis had not been added to the physician order for Lamotrigine as requested. During an interview on 01/16/25 at 3:00 PM, the Administrator revealed she thought the former DON would have been the person following-up to make sure pharmacy recommendations were completed. The Administrator stated she expected pharmacy recommendations to be addressed when provided to the facility.	F 756		
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.	F 812		2/12/25

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This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews the facility failed to maintain a clean floor in 1 of 1 walk-in cooler, 1 of 1 walk-in freezer, and 1 of 1 kitchen; label and date open food items and discard food with signs of spoilage or use-by date in 1 of 1 walk-in cooler; restrain facial hair during food preparation; and label and date food items in 2 of 2 nourishment room refrigerators and freezer (first and second floor nourishment rooms).

Findings included:

1. An initial tour of the walk-in cooler, walk-in freezer, and kitchen on 01/13/25 at 11:10 AM revealed multiple dried white stains and debris scattered on the floor of the walk-in cooler, dried brown stains and scattered debris on the floor of the walk-in freezer, and a dried blue substance to the kitchen floor near the 3 compartment sink, 2 plastic drinking cups on the floor under the dish machine, and a large amount of black debris on the floor under the sink near the dish machine.

An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed the walk-in cooler, walk-in freezer, and kitchen were mopped daily and she expected the floors to be clean.

An additional observation of the walk-in cooler, walk-in freezer, and kitchen floor on 01/15/25 at 11:10 AM revealed multiple dried white stains and debris scattered on the floor of the walk-in cooler, dried brown stains and scattered debris on the floor of the walk-in freezer, and a dried blue substance to the kitchen floor near the 3 compartment sink, 2 plastic drinking cups on the floor under the dish machine, and a large amount

F 812

1. Facility failed to maintain food safety requirements as noted by debris and stains on kitchen floor, floor of walk-in cooler, unlabeled and dated opened items in cooler and nourishment rooms, dietary staff were without proper hair nets and beard guards while in kitchen. All debris and stains noted within dietary department were removed 1/20/25. All food items that had not already been labeled / dated were discarded by dietary manager on 1/17/2025. Staff with facial hair were immediately given beard covers.

2. All residents residing in the facility that are served from the kitchen have the potential to be affected by the deficient practices. Food Service Director and Regional Food Service Director completed an audit of walk-in cooler and nourishment room refrigerators to ensure all food items were labeled and dated. Audit was completed on 1/20/25. Regional Food Service Director/Food Service Director also scheduled extra deep cleaning to be completed on 2/10/2025.

3. Education was completed to all dietary staff on 1/22/2025. Education including cleaning procedures for kitchen floors and walk-in cooler/freezer, proper dating and labeling of food items in walk-in cooler and nourishment room refrigerators, and donning hair nets and beards guards as indicated. Education was completed by Food Service Director.

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F 812

Continued From page 23
of black debris on the floor under the sink near the dish machine.

An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected floors of the walk-in cooler, walk-in freezer, and kitchen to be clean and free of debris.

2. An initial observation of the walk-in cooler on 01/13/25 at 11:15 AM revealed an undated bowl of salad, 3 opened and undated packs of sliced cheese, a bag of shredded lettuce with brown discoloration with an opened date of 01/02/25, a metal pan of tomato soup with a date of 01/07/25, and an opened and undated 46-ounce box of thickened orange juice sitting on a shelf.

An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed all food and beverage items should be dated when opened and cooks were responsible for making sure all items were dated on a daily basis. She stated any food with signs of spoilage should be discarded and the tomato soup should have been discarded 3 days after being placed in the cooler.

An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected all food and beverage items to be dated when opened, food with signs of spoilage should be discarded, and food items should be used or discarded according to use-by policies.

3. An observation of Cook #1 on 01/13/25 at 11:35 AM revealed he was preparing food for the lunch meal and did not have a restraint in place to cover his facial hair. Cook #1 had a partial beard with varying lengths of hair covering mainly his chin and the surrounding skin.

F 812

Food Service Director will complete an audit of kitchen sanitation, walk in freezer, dietary floors and dietary staff to ensure hair nets/beard guards are donned 5 times a week for one month, then twice a week for one month, and then weekly for one month to ensure all food items are labeled and dated. Regional Food Service Director will complete sanitation audit weekly for 12 weeks of kitchen sanitation, walk in freezer and dietary floors and dietary staff to ensure hair nets and beard guards are donned. New dietary staff will be educated on this process during orientation.

4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 2/3/25 to discuss this plan. Results of audits will be brought to the Quality Assurance Improvement meeting monthly for 3 months to ensure substantial compliance is achieved.

5. Date of Compliance 2/12/2025

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In an interview with Cook #1 on 01/13/25 at 11:35 AM he confirmed he was not wearing a restraint for his facial hair and stated he was not sure if the kitchen stocked restraints for facial hair.

An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed she had ordered beard guards but had not received them. She stated all employees with facial hair should have a beard guard in place when preparing and serving food.

An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected all dietary staff with facial hair to have a beard guard in place when preparing and serving food.

4. (a). An observation of the first-floor nourishment room refrigerator on 01/14/25 at 8:39 AM revealed an undated 46-ounce box of thickened apple juice sitting on a shelf.

(b). An observation of the second-floor nourishment room on 01/14/25 at 8:44 AM revealed the following:

(1) an unlabeled and undated bag of meatballs sitting in the door of the refrigerator
(2) an unlabeled and undated bag of pizza slices sitting in the door of the refrigerator
(3) an unlabeled and undated half empty thawed milkshake sitting on a shelf in the refrigerator
(4) an unlabeled and undated pitcher of brown liquid sitting on a shelf in the refrigerator
(5) an undated 12-ounce can of soda sitting on a shelf in the freezer
(6) 2 unlabeled and undated 16.9-ounce bottles of water sitting in the door of the freezer

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F 812	Continued From page 25 An interview with the Dietary Manager on 01/15/25 at 11:35 AM revealed the dietary department was responsible for ensuring all items in the nourishment room refrigerators and freezers were labeled and dated on a daily basis. She stated dietary staff would check to ensure all items were labeled and dated but nursing staff would place unlabeled and undated items in the refrigerators or freezers after dietary staff checked for dates and labels. An interview with the Administrator on 01/16/25 at 4:05 PM revealed she expected all items in nourishment room refrigerators and freezers to be labeled and dated.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure the area surrounding dumpsters remained free of garbage and debris and failed to close the doors to the dumpsters that contained waste for 3 of 3 dumpsters reviewed. These failures had the potential to attract pests and rodents. Findings included: An observation of the dumpster area with Cook #1 on 01/13/25 at 11:25 AM revealed the side doors of all 3 dumpsters were open and the door on top of the middle dumpster was open, with multiple cardboard boxes hanging out the top of	F 814	1. The facility failed to close the doors to dumpsters containing waste and to ensure that area surrounding the dumpsters was free from trash for 3 of 3 dumpsters. These failures had the potential to impact sanitary conditions and to attract pests and rodents. Dumpster doors were closed and debris on surrounding ground was cleaned by floor technician on 1/16/25. 2. These are the only three dumpsters on facility grounds. Audits were conducted on facility grounds to ensure no other debris was present by the Maintenance	2/12/25

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F 814	Continued From page 26 the dumpster. Further observation of the dumpster area revealed there were 3 gloves, a plastic drinking cup, pieces of tape, a straw, and various condiment packets scattered on the ground around the dumpster area. An interview with Cook #1 on 01/13/25 at 11:25 AM revealed he was not sure who was responsible for cleaning the dumpster area and ensuring dumpster lids were closed. An interview with the Dietary Manager on 01/13/25 at 3:04 PM revealed the maintenance department was responsible for cleaning the dumpster area. An interview with the Housekeeping Director on 01/17/25 at 8:26 AM revealed floor technicians and the maintenance department split keeping the dumpster area clean. She stated the dumpster area was supposed to be checked daily for cleanliness and that dumpster lids were closed. An interview with the Maintenance Director on 01/16/25 at 8:30 AM revealed he and the floor technicians were responsible for ensuring the dumpster area was clean and dumpster lids were closed on a daily basis. He stated he had not had an opportunity to check the dumpster area the morning of 01/13/25. An interview with Floor Technician #1 on 01/17/25 at 8:33 AM revealed he and the Maintenance Director were responsible for ensuring the dumpster area was clean and dumpster lids were closed on a daily basis. He stated he had not had an opportunity to check the dumpster area the morning of 01/13/25.	F 814	Director and Environmental Services Manager on 1/16/25. Any noted debris was disposed of in a proper receptacle. 3. Education was completed by the Administrator on 1/21/25 on requirement to keep dumpster doors and lids closed and the surrounding area free of trash/debris to prevent unsanitary conditions to Maintenance Director, Environmental Services Director and Dietary Manager. Environmental Services Director and Dietary Manager also provided Education to Housekeeping Staff, and Dietary Staff on ensuring that dumpster doors remain closed, and grounds are free of garbage and debris that may cause unsanitary conditions. Education was completed by Environmental Services Director/Designee as well as Dietary Manager/Designee on 1/25/25. Maintenance Director will schedule additional refuse disposal if needed. Newly hired mainenance director / environment servies direector/ housekeeping staff / dietary staff will be educated on this process in orienation. 4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 2/3/25 to discuss this plan. Audits will be conducted by Administrator/Designee of all dumpsters and surrounding grounds to ensure doors are closed an there is not any debris on ground weekly times 4 weeks, then monthly for 3 months. Results of audits will be discussed at the monthly Quality Assurance Improvement	

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F 814	Continued From page 27 An interview with the Administrator on 01/16/25 at 4:05 PM revealed all dumpster lids should be shut and the area around the dumpsters should be clean and free of debris. She stated the housekeeping department was responsible for ensuring the dumpster area was clean.	F 814	meeting for 3 months or until substantial compliance is achieved. 5. Date of compliance 2/12/2025	